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FINAL REPORT

Improving Alcohol and Tobacco Control During Pregnancy in Ukraine



DECEMBER 2015

This report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Elena Novichkova, Victor Boguslavsky, and Simon Hildebeitel of URC under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. The work of the USAID ASSIST Project is made possible by the generous support of the American people through USAID.

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DISCLAIMER

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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

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TABLE OF CONTENTS

List of Tables and Figures	i
Acronyms	ii
EXECUTIVE SUMMARY	iii
I. INTRODUCTION	1
II. MAIN ACTIVITIES	2
A. Start-up	2
B. Activities to Support BPI Implementation.....	3
C. Gender Integration	5
D. Institutionalization	5
III. RESULTS OF THE INTERVENTION	6
A. Characteristics of Pregnant Women at Their Initial Evaluation	7
B. Smoking Quit Rate.....	9
C. Stopping Alcohol Use.....	10
D. Patients' Perceptions of Information Provided during Physicians' Consultations.....	11
E. Counseling Pregnant Women on the Effects of Tobacco and Smoking.....	15
IV. DISCUSSION.....	17
V. RECOMMENDATIONS AND WAY FORWARD.....	18
VI. REFERENCES	19
APPENDICES	21
Appendix A: List of Participating Facilities in Poltava Oblast.....	21
Appendix B: Patient Screening Form (First Visit).....	22
Appendix C: Patient Screening Form (Second Visit)	24
Appendix D: Gender Integration Brief	26
Appendix E: BPI Training Curriculum Approved by the National Medical Academy of Postgraduate Education	28
Appendix F: Job Aids for Doctors and Patient Materials in Ukrainian	32

List of Tables and Figures

Table 1: Project overview.....	2
Table 2: Demographic background of pregnant women in Cohorts 1 and 2	7
Table 3: Smoking-related behavior of pregnant women in Cohorts 1 and 2	8
Table 4: Smoking environment and smoking-related beliefs of pregnant women in Cohorts 1 and 2	8
Table 5: Smoking behaviors of Cohorts 1 and 2.....	9
Table 6: Responses about alcohol use among Cohorts 1 and 2 (July 2014 – March 2015).....	10

Table 7: Changes in alcohol-related perceptions and behaviors from initial antenatal visit to follow up visit	10
Table 8: Physician consultation practices before and after BPI implementation, based on patient exit interviews	11
Table 9: Physician consultation practices before and after BPI implementation, based on patient exit interviews (only women whose reason for visit was expected pregnancy)	13
Table 11: Physician consultation practices before and after BPI implementation, based on patient exit interviews (women whose reason for visit was not expected pregnancy)	14
Table 12. Definitions of indicators, numerators, and denominators.....	17
Figure 1. Percentage of pregnant women who were screened for tobacco and alcohol use among those registered (Average of all facilities compared to individual facilities) (Aug 2014- Mar 2015)	15
Figure 2. Percentage of pregnant women receiving BPI intervention among those who test cotinine positive at their first consultation	16
Figure 3. Ukraine inflation rate (January 2014-June 2015)	18

Acronyms

ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
BPI	Brief physician intervention
CME	Continuing medical education
COP	Chief of Party
EBM	Evidence-based medicine
E&E	Europe and Eurasia
FAS	Fetal alcohol syndrome
FASD	Fetal alcohol spectrum disorders
HCI	USAID Health Care Improvement Project
HR	Human resources
MOH	Ministry of Health
MOU	Memorandum of understanding
NAMS	National Academy of Medical Science
NCD	Non-communicable disease
NMAPE	National Medical Academy of Postgraduate Education
OB/GYN	Obstetrics and Gynecology
PDSA	Plan-Do-Study-Act
QI	Quality improvement
TOT	Training of trainers
URC	University Research Co., LLC
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Introduction

The United States Agency for International Development (USAID) Applying Science to Strengthen and Improve Systems (ASSIST) Project began working in Ukraine in 2014 as a continuation of work begun under the USAID Health Care Improvement Project (HCI) in 2013 to implement a non-communicable diseases pilot activity in Poltava Oblast, also known as “Improving Alcohol and Tobacco Control During Pregnancy in Ukraine.” The work was funded by the USAID Europe and Eurasia Bureau.

The overall goal of this activity was to demonstrate the feasibility of use in Ukraine of an evidence-based, structured counseling protocol known as the *brief physician intervention* (BPI) to assist pregnant women to quit smoking and stop drinking alcohol. To achieve this goal, ASSIST also supported the Ministry of Health (MOH) in Ukraine by developing a national protocol for health facilities to incorporate BPI into the routine practice of health care providers in the country. The draft national protocol is being finalized for approval by the MOH and includes recommendations on BPI, the process of BPI delivery, recording and reporting tools, job aids, and referral mechanisms to specialty care.

Intervention

The following two key objectives were set up by the project:

- Secure at minimum 80% reduction in tobacco and alcohol use by pregnant women in selected facilities
- Secure at minimum 80% coverage of women of reproductive age (ages 15-49) with BPI and family planning counseling.

The intervention initially was to be implemented in the Luhansk and Poltava oblasts, however due to the political situation in Ukraine, the work was ultimately only implemented in Poltava Oblast. Nine facilities located in five cities in Poltava Oblast were included in the intervention. The project first conducted a “training-of-trainers” of national and local trainers on the use of BPI for tobacco and alcohol reduction. A baseline assessment was conducted in Poltava Oblast in July and August 2014 to establish patterns of alcohol and tobacco use among a cohort of pregnant women seen for initial evaluation in the facilities before BPI was introduced. Health care providers from the nine facilities were trained on BPI in August 2014, in a two-day training conducted jointly with the Oblast Health Care Department.

From September 2014 to March 2015, ASSIST provided coaching support to each of the nine facilities for BPI implementation and convened one-day learning sessions in December 2014 and March 2015 to facilitate sharing of experiences and results among providers regarding BPI implementation. An endline assessment was conducted among a different cohort of pregnant women seen for initial evaluation and followed up after the BPI intervention was introduced.

Results

Initial results from revealed that the immediate quit rate for smoking among the pre-intervention cohort of pregnant women (49%) was actually higher than that achieved by the post-intervention cohort (22%). Both cohorts had similar rates of reduction in alcohol consumption: in the pre-intervention cohort, pregnant women with alcohol use reduced their alcohol consumption from an average of 0.5 drinks per day to 0.15 drinks per day, and in the post-intervention cohort, pregnant women with alcohol use reduced consumption from 0.79 drinks per day to 0.48 drinks per day.

The intervention had positive effects on the percentage of pregnant women who were counseled about quitting tobacco and alcohol use by physicians. The data indicated that, from the patient’s perspective, doctors were more likely to ask women about smoking and alcohol use and more likely to advise pregnant women who smoke or drink alcohol to stop after the BPI training.

Further, patient record reviews showed an increase in the percentage of pregnant women screened by physicians for alcohol and tobacco use from 38% at baseline (July–August 2014) to 79% in March 2015. The target of providing BPI counseling to at least 80% of pregnant women who screened positive for tobacco use in all pilot facilities was reached on average (90%). For pregnant women who tested positive for alcohol use during their first antenatal visits and who received BPI, the 80% target was slightly underachieved (74%).

The data suggest that the processes of getting information on patient alcohol and tobacco use and providing appropriate advice—particularly counseling on the effects of tobacco and smoking—improved after the BPI training and implementation. The lack of improvement in pre- and post-intervention tobacco and alcohol usage rates among pregnant women was likely due to the political and economic instability—in particular, the rapidly increasing inflation in Ukraine over the period of activity implementation. During the study period, inflation rose from over 10% per month to almost 50% per month, which the authors believe may explain the significant differences between the smoking habits of women in the pre- and post-intervention cohorts.

Conclusions and Recommendations

The project faced a variety of technical and contextual challenges, particularly the rapid deterioration of political and economic stability that occurred in Ukraine beginning in June 2014 and that affected the design and implementation of the activity and therefore, its results. Despite these challenges, numerous efforts were undertaken to address much-needed institutionalization and sustainability of alcohol and tobacco-reduction interventions in Ukraine. The ASSIST and HCI projects supported a national multidisciplinary working group at the State Expert Center to prepare the national protocol for BPI. The projects also facilitated the institutionalization of BPI through working with care providers and health authorities at regional and national levels to support the incorporation of BPI into the routine practice of health care providers in the country. The USAID ASSIST Project also worked with the National Medical Academy of Postgraduate Education to incorporate the BPI training curricula into postgraduate medical education.

The growing evidence about prevalence of smoking and use of alcohol during pregnancy in Ukraine requires immediate attention and concerted efforts to raise awareness among childbearing women, adolescent girls, their families, and Ukrainian health care providers about the risks associated with tobacco and alcohol use in pregnancy and the effectiveness of evidence-based counseling techniques like BPI to reduce these risks. The introduction of the BPI protocol in Ukraine was shown to be feasible for use in primary care settings. We recommend it be integrated into routine care so that every patient who needs it, receives it.

I. INTRODUCTION

Alcohol and tobacco use in Ukraine is among the highest in the world [8, 13, 14] and puts heavy users at risk of cardiovascular disease, cancer, other non-communicable diseases (NCDs), and premature death. Among women of reproductive age (15-49 years), alcohol and tobacco use imposes a dual risk to the health of the woman and her baby. Heavy alcohol use during pregnancy creates a risk of fetal alcohol syndrome (FAS) and related disorders, including mental retardation and other cognitive problems, growth retardation, and problems with vision, hearing, and behavior [3,4,6,10,17]. Tobacco use during pregnancy increases the risk of miscarriage, preterm birth, low birth weight, and perinatal mortality, as well as asthma and sudden infant death syndrome [1, 2, 9, 18]. Maternal smoking during pregnancy has been associated with placental abruption and alterations in fetal growth, including reduction in head and abdominal circumference and femur length [5]. Despite a temporal decline in maternal smoking in the developed world, smoking still accounts for significant fetal and infant morbidity and mortality worldwide, and efforts to discourage prenatal smoking need to be intensified [5].

The United States Agency for International Development (USAID) Applying Science to Strengthen and Improve Systems (ASSIST) Project began working in Ukraine in 2014 as a continuation of similar work conducted through the USAID Health Care Improvement Project (HCI), funded by the USAID Europe and Eurasia (E&E) Bureau to implement a non-communicable diseases pilot activity known as “Improving Alcohol and Tobacco Control During Pregnancy in Ukraine.” The overall goal of this activity was to demonstrate the feasibility of use in Ukraine of an evidence-based, structured counseling protocol known as the *brief physician intervention* (BPI) to assist pregnant women to quit smoking and stop drinking alcohol. The intervention initially was to be implemented in the Luhansk and Poltava oblasts, however due to the political situation in Ukraine, the work was ultimately implemented in only Poltava Oblast. **Table 1** provides an overview of the intervention.

For the intervention, ASSIST and HCI worked in close coordination with the Ukrainian Ministry of Health (MOH), oblast health care authorities, the Ukrainian Medical and Monitoring Center on Alcohol and Drugs, and the National Medical Academy of Postgraduate Education (NMAPE) to enhance the capacity of Ukrainian health care providers and institutions to enable them to effectively deliver quality care and respond to the needs of patients to decrease alcohol and tobacco usage among pregnant women. Project-supported work in Ukraine included training health care providers and key decision-makers both at the national and local levels on an evidence-based BPI tobacco and alcohol cessation protocol, as well as supporting a national multidisciplinary working group at the State Expert Center to prepare the national protocol and guideline for BPI.

A BPI is a highly standardized counseling protocol, which takes approximately five minutes of an outpatient visit and is usually accompanied by a patient handbook. These protocols have been shown to be effective in studies in the United States promoting cessation of alcohol and tobacco use during pregnancy (most prominently, the SCRIPT trial [12, 20]) and have been endorsed by the United States Department of Health and Human Services (for tobacco) and the United States Preventive Services Task Force (for alcohol) [1,2,7,11,12, 19]. The approach is based on the “5 A’s”: “Ask” about substance use, “Advise” the patient to quit, “Assess” willingness to quit, “Assist” in quitting, and “Arrange” for follow-up (see **Appendix F3**).

ASSIST also facilitated the institutionalization of the new BPI protocol through working with local and national health authorities to support its incorporation into the routine practice of health care providers in the country. In addition, the project worked with the National Medical Academy of Postgraduate Education to incorporate the BPI training curricula into postgraduate medical education to further achieve sustainability objectives (see **Appendix E**).

Table 1: Project overview

What are we trying to accomplish?	Activities	Scale of intervention
<ul style="list-style-type: none"> To secure that 80% of pregnant women don't use tobacco and alcohol during pregnancy in selected facilities of Poltava Oblast To secure that 80% of women of reproductive age (15-49 years) are exposed to BPI and family planning counseling 	<ul style="list-style-type: none"> Training of trainers on BPI for quitting tobacco and alcohol use Training of health care providers on the use of BPI Two learning sessions for participating providers to facilitate shared learning from the implementation of BPI Coaching visits to each participating site Development of clinical-organizational protocol for BPI implementation nation-wide Development of a training curricula on BPI and facilitate incorporation of the curricula into post-graduate medical education in one-two medical education institutions in Ukraine 	<p>Oblast: Poltava</p> <p>Cities in Poltava Oblast: 5 (Poltava, Kremenchuk, Komsomolsk, Mirhorod, Lubny)</p> <p>Facilities: 9 (women's consultations, ambulatory polyclinics; see full list in Appendix A)</p> <p>Health care providers: 80 (obstetricians/gynecologists, midwives)</p> <p>Target population: pregnant women (primary), women of reproductive age and adolescent girls</p>

The project responded to priorities set by the Ukrainian Cabinet of Ministers Decree #1164p “On approving the Concept of the National Program Health 2020: Ukrainian Dimension” adopted on October 31, 2011 and contributed to the National Program “Reproductive Health of the Nation 2015” of the Ministry of Health of Ukraine approved by the Cabinet Decree #1849 on December 27, 2006.

This report describes the intervention implemented by HCI and ASSIST, including an overview of the project, the start-up and support activities, and activities to integrate gender considerations in the intervention. The report presents the results of the assessments conducted to determine the actual application of BPI and alcohol and tobacco use among pregnant women to measure BPI's effectiveness in reducing alcohol and tobacco usage and discusses the implications of these results for future programming in Ukraine.

II. MAIN ACTIVITIES

A. Start-up

The project's scope of work was approved by the USAID Europe and Eurasia Bureau and USAID Mission in Ukraine on February 11, 2013. Effective March 9, 2013, Dr. Elena Novichkova, Country Resident Advisor and Ms. Katerina Bazayants, Administrative and Financial Officer, began their employment with University Research Co., LLC (URC) in Ukraine.

On March 18, 2013, the activity's scope of work in Ukrainian along with a letter were submitted to Dr. O. Tolstanov, Deputy Minister of Health of Ukraine, for further approval and to obtain recommendations on regions proposed for inclusion in the activity.

On May 13, 2013, a Memorandum of Understanding (MOU) was signed between the MOH and University Research, Co., LLC as the implementing partner for cooperation on the “USAID Improving Alcohol and Tobacco Control during Pregnancy in Ukraine” project. Letters of cooperation were also signed by the health care departments from Luhansk and Poltava oblasts and the Ukrainian Medical and Monitoring Center on Alcohol and Drugs.

Following the signing of the MOU, an activity launch was jointly sponsored by USAID and the MOH on June 11, 2013. The event brought together stakeholders to present and discuss key findings on alcohol and tobacco use among pregnant women and women of reproductive age in Ukraine, the project's goal and objectives, key technical assistance activities, expected results, the implementation strategy, and approaches to evaluation. Thirty participants attended, representing the Ministry of Health of Ukraine, the USAID Regional Mission for Ukraine, the Verhovna Rada's Subcommittee on Maternal and Child Care and Women's Reproductive Health, the MOH's Department of Public Health, the State Expert Center for Standardization of Medical Services, the Ukrainian Information Center for Alcohol and Substance Abuse Issues, the Shupik National Medical Academy for Postgraduate Education, the World Health Organization, the European Commission, the health departments of Luhansk and Poltava oblasts, the All-Ukrainian Medical Society, the Regional Center of Civil Society Representatives "Zhittya", and private clinics. The event and photos were posted on the MOH's website http://www.moz.gov.ua/ua/portal/pre_20130611_a.html.

On August 30, 2013 the project was registered with the Ministry of Economy Development and Trade.

URC also issued consultant agreements with two US-based experts (Dr. Richard Windsor from George Washington University and Dr. Tatiana Balachova from the University of Oklahoma) to provide technical support for the training in BPI and the project's evaluation activities.

B. Activities to Support BPI Implementation

Planning for the implementation of the BPI intervention began in October 2013. The project team set up technical meetings and a conference in Kyiv with Dr. Richard Windsor, USAID representatives, local experts from the Ukrainian MOH, academic institutions, and representatives from participating facilities in the two oblasts to discuss BPI protocols for reducing alcohol use and smoking cessation, as well as to plan for the baseline assessment, the process of BPI implementation, and the evaluation of the intervention's effectiveness. As part of the event, a visit to Poltava Oblast was organized to meet the Director of Oblast Health Care Department and selected women's consultation polyclinics to gain knowledge about current health care provider counseling practices of pregnant women and women of reproductive age on issues such as smoking and alcohol use in pregnancy and family planning.

The project team in Ukraine began preparing the baseline assessment tools, conducted introductory visits to health facilities in Luhansk and Poltava oblasts, and applied for an official registration with the State Administration of Ukraine on Medical Products of cotinine tests to validate the tobacco consumption of the target population.

The protocol "Quality Improvement-Formative Evaluation" received approval from the Scientific Board of the State Ukrainian Institute of Reproduction on March 20, 2014. In parallel, the protocol was also approved by URC's Institutional Review Board.

Due to massive political protests initiated in Kyiv in January 2014 and further escalations, the preparation for implementation was significantly slowed down. The project team continued to prepare for baseline assessments and training of care providers in the two oblasts. Further deteriorations in Eastern Ukraine in June 2014 led to a decision to stop the activity in Luhansk Oblast and to focus solely on Poltava Oblast by adding more health facilities. The decision was coordinated with the USAID Mission in Ukraine and the USAID Europe and Eurasia Bureau.

After Luhansk Oblast was dropped from the project, per an agreement with the Poltava Oblast Health Care Department, a polyclinic in Mirgorod Central Regional Hospital was added as a site where the project would be implemented. The numbers of participating physicians in all nine facilities were increased from 50 to 80. This facility was added in August 2014 but did not participate in the baseline assessment since all baseline assessments had already completed by that time.

A **training of trainers** (TOT) on BPI for tobacco and alcohol use was conducted by ASSIST on July 1-3, 2014 in Poltava City to prepare 12 national and local trainers on the BPI methodology. The selection of trainers was done in coordination with the USAID Healthy Women of Ukraine Project. Trainings were delivered by Drs. Richard Windsor, Tatiana Balachova, and Elena Novichkova. The training curriculum included theoretical and practical sessions during which the participants were able to practice BPI counseling techniques. The TOT materials were later adapted by Shupyk National Medical Postgraduate Academy Leadership for use in ongoing postgraduate medical education of primary care providers.

A **baseline assessment** was conducted by ASSIST in Poltava Oblast during July–August 2014 to assess alcohol and tobacco use among pregnant women, document the level of self-reporting, and define the deception rate. Pregnant women (672) were assessed for tobacco and alcohol use during their first antenatal visits and then during a second visit that occurred 3-4 weeks later. Self-reported responses about smoking were validated by urine dipsticks for cotinine. (The assessment methodology and key findings are presented in Section III. Results of the BPI Intervention).

A **training for health care providers** on BPI was conducted by ASSIST in Poltava on August 28-29, 2014 in conjunction with the Oblast Health Care Department. The training was attended by 80 health care providers. The post-training evaluation revealed that knowledge levels among providers increased by 30% (min15%; max 55%) on day 1, and by 40% (min 30%; max 55%) on day 2. The BPI training and implementation materials developed by ASSIST included:

- Technology of BPI to decrease tobacco and alcohol consumption by women of reproductive age and pregnant women: Methodological recommendations for doctors (see **Appendix F1**)
- Workbook for pregnant women to quit smoking and drinking alcohol (see **Appendix F4**)
- Standard dose of alcohol – short pocket card (see **Appendix F1**)
- BPI – 5”A” algorithm for quitting smoking and drinking alcohol – short pocket card (see **Appendix F3**)
- Audit test (short version) – pocket card (see **Appendix F2**)

The **BPI implementation phase** occurred from September 15, 2014 until March 2015. Interventions during the implementation phase included: screening all pregnant women who came to the nine intervention facilities for the first prenatal (antenatal) visit; physicians completing patients’ screening forms for the first and second visits (see **Appendices B** and **C**, respectively); and patient’s undergoing the urine diagnostic test for cotinine. If a patient was positive for tobacco use (cotinine test) or used alcohol, the physician provided immediate BPI consultation in accordance with the BPI protocol. A second visit was scheduled within three weeks for all cotinine-positive patients.

During the BPI implementation period, ASSIST organized and provided **coaching support** to health care providers. Coaches (monitors) were trainers and specialists in obstetrics and gynecology who had prior experience in conducting professional audits and working with other international projects. Five **monitoring visits** were conducted to each of nine facilities (45 visits overall) from December 2014 to March 2015 to check the status of BPI implementation, the quality of screening, review how forms were being filled out, and discuss with teams any barriers to implementing the new protocol and how to overcome them.

To facilitate **shared learning** between health care providers on the BPI implementation, the results of these visits were recorded and reported during two one-day **learning sessions** held in December 2014 and March 2015, respectively, and at the Oblast Health Care Department meeting in March 2015. The sessions were attended by 60 participants who represented the nine pilot facilities/polyclinics of Poltava city and oblast. During the learning sessions, participants discussed challenges with BPI implementation, presented data, reviewed results, and planned further steps toward BPI implementation. Evidence from the coaching visits showed improvement in access to screening and provision of brief counseling services for pregnant women in participating facilities.

On June 12, 2015, ASSIST held a **final project conference** in Kyiv. The event brought together stakeholders to present and discuss key achievements. Welcoming remarks were made by Charles Lerman, Director Office of Health, USAID/Regional Mission for Ukraine, Belarus, and Moldova, and by Dr. Igor Perogov, Deputy Director of the Health Care Department of Poltava Oblast. The event was attended by 38 participants representing the MOH's Department of Public Health, Department of Maternal and Child Health, State Expert Center for Standardization of Medical Services, Health Care Department of Poltava Oblast, Ukrainian Medical and Monitoring Center on Alcohol and Drugs, leadership of participating health facilities from Poltava Oblast, State Directorate for Affairs, Shupik National Medical Academy for Postgraduate Education, Ukrainian Office of the World Health Organization, Regional Center of Civil Society "Health Right" International, USAID "Healthy Women of Ukraine" Project, "Mother and Child Health" Program of Switzerland, Health Care Management Department of Bogomolets' National Medical University, and the World Bank Group in Ukraine. The Deputy Director of Poltava Health Care Department reported on key results and presented next steps for strengthening system changes at the regional level. A Chief Doctor of a participating polyclinic presented on results achieved and challenges faced. The Vice-Rector of the Academy for Post-graduate Medical Education reported on plans for incorporating training curricula into the course of postgraduate medical education. The Director of Department for Standardization of Medical Services described plans for incorporation BPI protocol tested in Poltava Oblast into the national protocol.

C. Gender Integration

To explore the role of gender in facilitating achievement of positive health outcomes from the implementation of BPI, ASSIST's partner for gender integration, WI-HER LLC, supported the design of a survey to better understand how gender impacts alcohol and tobacco use and violence during pregnancy in Ukraine. In September 2014, a survey was developed by the project team with inputs from WI-HER LLC. Data were collected from 617 women of reproductive age (including 209 pregnant women) that visited participating women's consultation clinics in Poltava Oblast. Survey findings revealed that 42.5% of pregnant woman reported being exposed to secondhand smoke, and 6.5% of women surveyed reported being subjected to physical violence. In October 2014, with assistance from WI-HER's consultant Ms. Megan Ivankovich, two gender integration trainings were conducted for nine doctors in Poltava and seven national level trainers in Kyiv on how to address gender during the implementation of BPI. Sessions included defining gender and related concepts, conducting gender analyses and how to address gaps, analyzing and reporting results through sex-disaggregated data and gender-sensitive indicators. Following the trainings, changes in language were made in the patient counseling materials and doctor recommendations. The project developed a brief about the role of gender in alcohol and tobacco cessation among pregnant women and adolescents that was presented at a learning session in December 2014 (see **Appendix D**). It was recommended to providers that they promote male participation in antenatal care consultations to increase male partners' awareness of the negative effects of alcohol and tobacco exposure during pregnancy.

D. Institutionalization

To facilitate the institutionalization of the BPI implementation nationwide, the project worked with the Ministry of Health to set up a working group that would review the evidence for implementing the BPI to assist pregnant women to quit smoking and stop drinking alcohol and develop a national protocol on BPI. The working group was formally set up by MOH's Order N951 issued on December 11, 2014. Members of the working group included national experts and Dr. Novichkova. Expert consultation by ASSIST's consultants was provided to the group on global evidence on the impact of BPI on the reduction of tobacco and alcohol use during pregnancy.

Based on global and in-country evidence, the working group developed a draft clinical protocol "Brief physician interventions to decrease tobacco and alcohol use among pregnant women". The protocol includes the following: 1) Guide for preventive screening for women of reproductive age who plan their

pregnancy or registered as pregnant during their first visit to a primary health care facility; 2) Guidance on BPI implementation, including identification of risk factors and two controls during prenatal visits; 3) Guidance on registration and documentation of the use of screening tools, counseling, and follow-up that was based on BPI implementation in Poltava Oblast; 4) Quality indicators; and 5) Educational materials for pregnant women and doctors to assist them with counseling consulting sessions. It is anticipated that during 2015, the protocol will undergo public debates, review, and will be officially recommended by the MOH for use in Ukraine. Approval of the protocol is expected by the beginning of 2016.

Based on the training of trainers' curriculum, a draft training curriculum was adopted by Ukrainian partners with support from ASSIST and submitted to the Methodological Council and Scientific Council of the NMAPE for approval and incorporation into the postgraduate medical education program for primary care physicians. The curriculum was approved on September 17, 2014 (a copy of an approved cover page and the curriculum summary are presented in **Appendix E**). The curriculum is being offered starting in the academic year commencing in September 2015.

III. RESULTS OF THE INTERVENTION

The BPI intervention sought to achieve two key objectives:

- Secure at minimum 80% of reduction in tobacco and alcohol use by pregnant women in selected facilities
- Secure at minimum 80% coverage of women of reproductive age (ages 15-49) with BPI and family planning counseling.

ASSIST conducted a pre-/post-intervention comparison in which behavioral changes in alcohol and tobacco use among a cohort of pregnant women seen for initial evaluation in the pre-intervention period (Cohort 1) July – August 2014, were compared to results in a different cohort of pregnant women who were seen for initial evaluation and then followed-up after the BPI intervention (Cohort 2), September 15, 2014 – March 2015.

Key objectives of the pre- and post-intervention evaluations included:

1. Assess patients' perceptions of information provided during the physician's consultation
2. Assess levels of smoking and alcohol use among pregnant women attending antenatal care in participating facilities
3. Estimate differences between the percent of pregnant women who test positive on the dipstick cotinine test before and after BPI implementation
4. Collect data about changes in reported alcohol consumption between first and second prenatal care clinic visits

In order to carry out the survey, all women of reproductive age at risk for pregnancy and those who attended antenatal care in participating outpatient clinics were asked by physicians whether they wanted to participate in the survey, to fill out informed consent forms, and were administered a face-to-face screening form on tobacco and alcohol use. Prior to administering the survey, the questionnaires to screen for tobacco and alcohol use during pregnancy for first and second follow-up visits were translated into Ukrainian, pretested, and approved for use in clinics by the Poltava Oblast Health Care Department. The forms in English are presented in **Appendices B** and **C**. After the screening forms were administered, two copies were made. The first copy of each patient's screening form was collected by an assigned medical staff, and the second copy was kept in the patient's medical records/ambulatory card. All first copies were sent by project staff to the Ukrainian Medical and Monitoring Center on Alcohol and Drugs for entry into an Excel data file. Survey respondents were identified only by their medical record

number. No personal data of patients were made available. Physicians who filled out the screening forms and provided counseling were identified only by individual codes.

A. Characteristics of Pregnant Women at Their Initial Evaluation

At the initial evaluation, there were slight differences between the demographics of Cohorts 1 and 2. While women in both cohorts were of similar age, Cohort 2 on average came for their initial evaluations later in their pregnancy, were less likely to be single, and had higher educational levels than women in Cohort 1 (**Table 2**). Pregnant women in Cohort 2 on average returned for their follow-up visit earlier than those in Cohort 1. These factors were controlled for in statistical analyses.

Table 2: Demographic background of pregnant women in Cohorts 1 and 2

	Cohort 1 (n = 652)	Cohort 2 (n = 3159)	
Age (years)	26.9 n = 592	27.0 n = 3045	p=0.799
Marital status	Civil marriage 24% (154) Married 60% (388) Single 16% (105) Widow 0% n = 647	Civil marriage 28% (869) Married 59% (1841) Single 13% (420) Widow 0.1% (3) n = 3133	p=0.075
Educational status among pregnant women	Higher/master 41% (265) Incomplete higher/bachelor 10% (63) Secondary/incomplete secondary 27% (175) Special secondary 22% (141) n = 644	Higher/master 45% (1371) Incomplete higher/bachelor 10% (293) Secondary/incomplete secondary 22% (651) Special secondary 23% (708) n = 3023	p=0.017
Gestation at first visit (weeks)	12.0 n = 628	12.6 n = 3100	p=0.021
Days between initial evaluation and follow-up visit	Mean = 28.9 n = 543	Mean = 19.6 n = 538	p<0.001

A higher percentage of women in Cohort 1 than in Cohort 2 were smokers: When including pregnant women who either tested cotinine positive or admitted to smoking as women who smoke in Cohort 1, 19% of pregnant women were smokers at initial evaluation, while in Cohort 2 only 13% of pregnant women smoked (**Table 3**).

The difference in smoking rates between the two cohorts suggests that factors outside the intervention may have influenced those rates. One obvious outside factor was the high and steadily increasing rate of inflation in Ukraine during the study period (see discussion section below). It is highly likely that the economic situation in Ukraine may have contributed substantially to the decrease in smoking among pregnant women in this study even before exposure to the BPI intervention.

This apparent difference in smoking rates between Cohort 1 and 2, is mirrored by a small but statistically significant difference in the smoking environment and attitudes towards smoking among pregnant women in the two cohorts. More women in Cohort 2 at their initial evaluation believed smoking was harmful to themselves and their fetus and they were less likely to live with smokers and have smokers among their peers than pregnant women in Cohort 1 (**Table 4**).

Table 3: Smoking-related behavior of pregnant women in Cohorts 1 and 2

	Cohort 1	Cohort 2	
Percentage of pregnant women who agreed to a cotinine at initial visit	Yes = 93% (599) No/refusal = 7.0% (43) n = 642	Yes = 98% (3035) No/refusal = 2% (74) n = 3109	p<0.001
Result of cotinine test	Positive = 18.1% (113) Negative = 81.9% (511) n = 624	Positive = 12.3% (375) Negative = 87.7% (2679) n = 3054	p<0.001
Are you a smoker?	Yes = 10.2% (66) No = 89.8% (583) n = 649	Yes = 8.8% (277) No = 91.2% (2857) n = 3134	p=0.283
Did pregnant women who tested cotinine positive admit smoking?	Yes = 49.6% (56) No = 50.4% (57) n = 113	Yes = 65.3% (245) No = 34.7% (130) n = 277	p=0.003
Smokes at first visit (includes all pregnant women who test positive and those who say they are smokers)	Yes = 19.0% (123) No = 81.0% (526) n = 649	Yes = 13.0% (407) No = 87.0% (2727) n = 3134	p<0.001

It may be that pregnant women more likely to quit smoking had already done so in Cohort 2 compared to Cohort 1 meaning there may have been a greater proportion of pregnant women profoundly addicted to smoking in Cohort 2. Such major external changes affecting the study setting were not accounted for in the study design, and as such, this factor could not be accounted for in the analysis.

Table 4: Smoking environment and smoking-related beliefs of pregnant women in Cohorts 1 and 2

	Cohort 1 (Baseline)	Cohort 2 (End line)	
Smoking practice where pregnant woman lives	Nobody smokes = 82.3% (526) Specific rooms = 16.1% (103) Anywhere = 1.6% (10) n = 639	Nobody smokes = 87.5% (2605) Specific rooms = 12.2% (362) Anywhere = 0.4% (12) n = 2979	p<0.001
Proportion of smokers among friends and relatives	Majority = 7.9% (51) Half = 10.5% (68) Several = 65.3% (423) None = 16.3% (106) n = 648	Majority = 5.3% (166) Half = 9.9% (309) Some = 66.8% (2081) None = 18.0% (559) n = 3115	p=0.068
Based on your knowledge, how harmful is tobacco for you? (10-point scale:	Answered 10 = 87.3% (568) Mean answer = 9.59 n = 651	Answered 10 = 93.5% (2747) Mean answer = 9.83 n = 2938	p <0.001

	Cohort 1 (Baseline)	Cohort 2 (End line)	
10 = very harmful, 1 = harmless)			
Based on your knowledge, is own smoking or people around you smoking harmful for your fetus? (10-point scale)	Answered 10 = 92.3% (602) Average answer = 9.74 n = 652	Answered 10 = 96.1% (2859) Average answer = 9.89 n = 2976	p <0.001

B. Smoking Quit Rate

The primary outcome of interest was the BPI intervention's effect on the smoking quit rate calculated using the formula:

$$\frac{\# \text{ pregnant women who test cotinine-negative at follow-up} - \# \text{ pregnant who admit smoking at follow-up}}{\# \text{ pregnant women who test cotinine-positive at first visit} + \# \text{ pregnant who admit smoking at first visit}}$$

pregnant women who test cotinine-positive at first visit + # pregnant who admit smoking at first visit

Pregnant women who admitted to smoking at the first visit were included in the denominator, even if they refused the cotinine test. Because these women were included in the denominator, they were excluded from the numerator. Using this formula, the immediate quit rate for Cohort 1 was 49% and the immediate quit rate for Cohort 2 was 22% (Table 5). However, this difference may not accurately represent the true difference between cohorts because there was a large difference in the percentage of pregnant women for whom no follow-up data was collected (11% for Cohort 1 and 35% for Cohort 2). To account for this difference, we also calculated the immediate quit rate among pregnant women who did have a follow-up visit, disregarding pregnant women for whom we do not have follow-up data. Among this group, the immediate quit rate for Cohort 1 (55%) still significantly exceeds that of Cohort 2 (34%).

Table 5: Smoking behaviors of Cohorts 1 and 2

	Cohort 1	Cohort 2	
Women who tested positive or admitted smoking at initial evaluation	123	407	
Women confirmed to have stopped smoking at follow-up visit (tested cotinine-negative and denied smoking)	60 (49%)	89 (22%)	p<0.001
Immediate quit rate	49% (60/123)	22% (89/407)	p<0.001
Number of women with no follow-up visit or had no cotinine test at follow-up	13 (11%) (No follow-up visit=10, no follow-up cotinine test=3)	142 (35%)	p<0.001
Is a smoker at follow-up (tests positive or admits smoking)	Stopped smoking = 55% (60) Still smokes = 45% (50) n = 110	Stopped smoking = 34% (89) Still smokes = 66% (176) n = 265	p<0.001

C. Stopping Alcohol Use

The second outcome of interest was reduction in alcohol use. As with the smoking data, it appears that pregnant women's drinking practices were different from Cohort 1 and 2: fewer pregnant women at their initial visit admitted to binge drinking (drinking 6 or more standard drinks in one day) in Cohort 2 (4%) compared to Cohort 1 (17%) (**Table 6**) and women in Cohort 2 were more likely to believe that drinking beer or wine could harm their baby (**Table 7**).

We did not observe that the BPI intervention led to a reduction in alcohol consumption: Similar rates of reduction in alcohol consumption were observed in the pre-intervention cohort and post-intervention cohort (pregnant women with alcohol use reduced their alcohol consumption from an average of 0.5 drinks per day to 0.15 drinks per day, while pregnant women with alcohol use reduced consumption from 0.79 drinks per day to 0.48 drinks per day (**Table 7**).

Table 6: Responses about alcohol use among Cohorts 1 and 2 (July 2014 – March 2015)

	Cohort 1	Cohort 2	
1 month BEFORE you knew you were pregnant how many days did you drink 6 or more standard drinks in one day? (visit 1)	Among women who drank 6 or more drinks at least once: Mean = 2.08 n = 102 17% of women said they drank 6 or more drinks at least once n = 613	Among women who drank 6 or more drinks at least once: Mean = 1.78 n = 108 4% of women said they drank 6 or more drinks at least once n = 2752	p=0.303 p<0.001
On average, in the last 30 days, how many days per week did you drink?	None = 80% mean = 0.31 n = 638 (Among drinkers, mean = 1.56, n = 126)	None = 75% Mean = 0.34 n = 3072 (Among drinkers, mean = 1.36, n = 777)	p=0.260 p=0.012
When you did drink usually, how many standard drinks would you have in a day?	Mean = 0.49 n = 628	Mean = 0.48 n = 2771	p=0.888

In both Cohorts 1 and 2 pregnant women were more likely to say it was not good to drink when pregnant and that drinking may harm their baby at their follow-up visit, and reported drinking less at their follow-up visits in both cohorts. Overall, the pregnant women showed larger gains in their perceptions about the harm caused by alcohol, but the difference in gain between Cohorts 1 and 2 was not statistically significant. Likewise, while both groups reported drinking less, the difference in reduction between Cohorts 1 and 2 was not statistically significant (**Table 7**).

Table 7: Changes in alcohol-related perceptions and behaviors from initial antenatal visit to follow up visit

	Cohort 1		Cohort 2		Difference made by intervention
	Initial evaluation	Follow-up	Initial evaluation	Follow-up	
On a 1-10 scale, do you believe pregnant women may drink, but not abuse	Mean = 9.06 n = 583	Mean = 9.20 n = 583	Mean = 8.84	Mean = 9.05 n = 549	

	Cohort 1		Cohort 2		Difference
alcohol?		Diff = +0.14 p=0.324	n = 549	Diff = +0.21 p=0.162	+0.08 p=0.623
Do you believe drinking beer or red wine during pregnancy may harm the baby? (10-point scale)	Mean = 9.24 n = 586	Mean = 9.47 n = 586 Diff = +0.23 p=0.03	Mean = 9.17 n = 546	Mean = 9.60 n = 546 Diff = +0.43 p<0.001	+0.21 p=0.111
On average in the last 30 days, how many days per week did you drink alcohol?	Mean = 0.32 n = 563	Mean = 0.06 n = 563 Diff = -0.26 p<0.001	Mean = 0.68 n = 544	Mean = 0.39 n = 544 Diff = -0.29 p<0.001	-0.03 p=0.472
When you drank, usually how many standard drinks would you have per day?	Mean = 0.50 n = 534	Mean = 0.15 n = 534 Diff = -0.35 p<0.001	Mean = 0.79 n = 502	Mean = 0.48 n = 502 Diff = -0.31 p<0.001	+0.04 p=0.512

D. Patients' Perceptions of Information Provided during Physicians' Consultations

After initial evaluation, women were given an anonymous exit-questionnaire they completed before leaving the clinic. This questionnaire was designed to assess whether or not physicians were providing appropriate information during consultations. The data indicated that, from the patient's perspective, physicians were more likely to ask women about smoking and alcohol use and more likely to advise pregnant women who smoke or drink alcohol to stop after the BPI training. These data suggest that physicians were providing appropriate advice to pregnant women on alcohol and tobacco use—particularly counseling on the effects of tobacco and smoking—more frequently after the BPI training, which was a key goal of project implementation (Tables 8, 9, and 10).

Table 8: Physician consultation practices before and after BPI implementation, based on patient exit interviews

	Patient survey Cohort 1 (n = 1061)	Patient survey Cohort 2 (n = 1237)	
Reason for visit to a women's consultation unit (total greater than 100% as some women gave more than one reason)	35% Expect pregnancy (402) 24% Preventive visit (302) 7% Acute disease (87) 25% Follow up visit (306) 8% Other (131) n = 1228	29% Expect pregnancy (360) 37% Preventive visit (463) 10% Acute disease (122) 18% Follow-up visit (230) 7% Other (87) n = 1262	p<0.001
Age	18 and under – 13% (133) 19-44 – 73% (756) 45+ – 15% (157) n = 1046	18 and under – 17% (206) 19-44 – 70% (856) 45+ – 15% (165) n = 1227	p=0.021

	Patient survey Cohort 1 (n = 1061)	Patient survey Cohort 2 (n = 1237)	
Doctor asked me whether I use contraceptives or plan my pregnancy	78% (682) n = 876	87% (958) n = 1103	+9% p<0.001
Among women age 44 and younger	82% (643) n=780	92% (911) n=991	+10% p<0.001
Doctor asked me whether I drink alcohol	73% (720) n = 983	91% (1072) n = 1180	+18% p<0.001
Doctor asked me whether I smoke tobacco	74% (739) n = 994	91% (1085) n = 1191	+17% p<0.001
Doctor spoke about the impact of alcohol and tobacco use on women's health	74% (708) n = 961	93% (1086) n = 1170	+19% p<0.001
Doctor told me about the impact of alcohol and tobacco use during pregnancy	74% (645) n = 866	89% (926) n = 1043	+15% p<0.001
Doctor advised me to quit smoking	75% (156) n = 207 (smokers only)	91% (341) n = 375	+16% p<0.001
Doctor told me to quit drinking alcohol or use reliable contraceptives.	62% (98) n = 159 (drinkers only)	88% (312) n = 353 (drinkers only)	+26% p<0.001
Doctor discusses how to reach this goal and explained possible difficulties	65% (502) n = 771	76% (692) n = 911	+11% p<0.001
Doctor asked me to come for a follow-up visit.	89% (843) n = 952	86% (976) n = 1137	-3% P=.066
Would like comprehensive, credible information on the impact of alcohol and tobacco use on own health and that of my children and relatives	43% (374) n = 872	57% (596) n = 1051	+14% p<0.001

Table 9 shows the results for only women whose reason for visit to the health facility was expected pregnancy. **Table 10** shows the results for only women whose reason for visit to the health facility was not expected pregnancy.

Table 9: Physician consultation practices before and after BPI implementation, based on patient exit interviews (only women whose reason for visit was expected pregnancy)

	Patient survey Cohort 1 (n = 402)	Patient survey Cohort 2 (n = 360)	
Additional reasons of visit to a women's consultation unit (women could list more than 1)	Preventative visit (31) Acute disease (14) Follow up (78) Other (11)	Preventative visit (9) Acute disease (1) Follow up (16) Other (4)	p=0.451
Age	18 and under – 13% (46) 19-44 – 73% (346) 45+ – 15% (5) n = 397	18 and under – 17% (64) 19-44 – 70% (289) 45+ – 15% (4) n = 357	p=0.048
Doctor asked me whether I use contraceptives or plan my pregnancy.	83% (264) n = 317	88% (264) n = 301	+5% p=0.119
Doctor asked me whether I drink alcohol	86% (330) n = 382	97% (340) n = 352	+9% p<0.001
Doctor asked me whether I smoke tobacco	86% (330) n = 382	97% (339) n = 351	+9% p<0.001
Doctor spoke about the impact of alcohol and tobacco use on women's health	85% (304) n = 357	97% (330) n = 341	+12% p<0.001
Doctor told me about the impact of alcohol and tobacco use during pregnancy	89% (323) n = 361	99% (334) n = 339	+10% p<0.001
Doctor advised me to quit smoking	88% (57) n = 65 (smokers only)	95% (92) n = 97 (smokers only)	+7% P=0.100
Doctor told me to quit drinking alcohol or use reliable contraceptives	75% (38) n = 51 (drinkers only)	91% (75) n = 82 (drinkers only)	+16% p=0.008
Doctor discusses how to reach this goal and explained possible difficulties	73% (212) n = 291	82% (218) n = 265	+9% p=0.008
Among smokers:	83% (58) n=70	94% (95) n=101	+11% p=0.019
Among drinkers:	75% (46) n=61	93% (77) n=83	+18% p=0.004
Doctor asked me to come for a follow-up visit	96% (357) n = 373	97% (339) n = 348	+1% p=0.212

	Patient survey Cohort 1 (n = 402)	Patient survey Cohort 2 (n = 360)	
Would like comprehensive, credible information on the impact of alcohol and tobacco use on own health and that of my children and relatives	43% (145) n = 341	61% (188) n = 308	+18% p<0.001

Table 10: Physician consultation practices before and after BPI implementation, based on patient exit interviews (women whose reason for visit was not expected pregnancy)

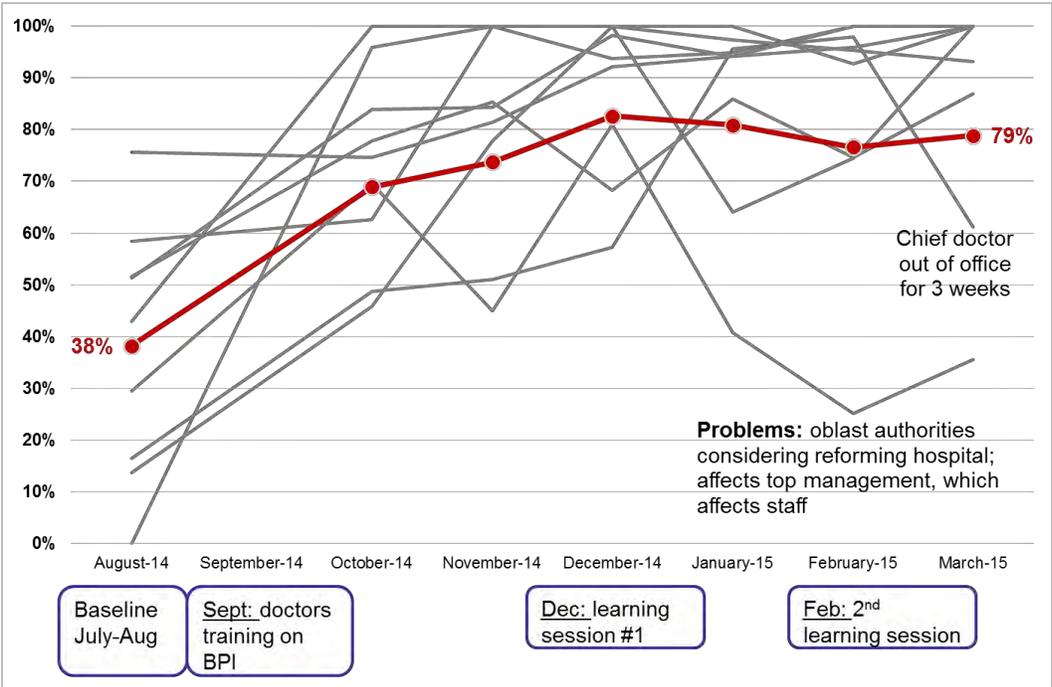
	Patient survey before baseline assessment (n = 659)	Patient survey after BPI implementation (n = 877)	
Reason of visit to a women's consultation unit (total greater than 100% as some women gave more than one reason)	39% Preventive visit (271) 11% Acute disease (73) 35% Follow up visit (228) 18% Other (120) n = 692	52% Preventive visit (454) 14% Acute disease (121) 24% Follow-up visit (214) 9% Other (83) n = 872	p<0.001
Age	18 and under – 13% (87) 19-44 – 63% (410) 45+ – 23% (152) n = 649	18 and under – 16% (142) 19-44 – 65% (567) 45+ – 19% (161) n = 870	p=0.035
Doctor asked me whether I use contraceptives or plan my pregnancy.	75% (418) n=559	87% (694) n=802	+12% p<0.001
Doctor asked me whether I drink alcohol	65% (390) n=601	88% (732) n=828	+13% p<0.001
Doctor asked me whether I smoke tobacco	67% (409) N=612	89% (746) N=840	+22% p<0.001
Doctor spoke about the impact of alcohol and tobacco use on women's health	67% (404) n=604	91% (756) n=829	+24% p<0.001
Doctor told me about the impact of alcohol and tobacco use during pregnancy	64% (322) n=505	84% (592) n=704	+20% p<0.001
Doctor advised me to quit smoking	70% (99) n=142 (among smokers only)	90% (249) n=278 (among smokers only)	+20% p<0.001
Doctor told me to quit drinking alcohol or use reliable contraceptives.	56% (60) n=108 (among drinkers only)	87% (237) n=271 (among drinkers only)	+31% p<0.001

	Patient survey before baseline assessment (n = 659)	Patient survey after BPI implementation (n = 877)	
Doctor discusses how to reach this goal and explained possible difficulties	60% (290) n=480	73% (474) n=646	+13% p<0.001
Doctor asked me to come for a follow-up visit.	84% (486) n=579	81% (637) n=789	-3% p=0.127
Would like comprehensive, credible information on the impact of alcohol and tobacco use on own health and that of my children and relatives	43% (229) n=531	55% (408) n=743	+12% p<0.001

E. Counseling Pregnant Women on the Effects of Tobacco and Smoking

Timely assessment of pregnant women for tobacco use and their counseling about quitting smoking provides a higher chance that a mother will quit smoking during pregnancy, which in turn can improve her health and help prevent negative outcomes for her fetus and newborn. Data analysis showed an increase in the percentage of pregnant women screened for alcohol and tobacco from 38% at baseline in August 2014 to 79% in March 2015 (Figure 1).

Figure 1. Percentage of pregnant women who were screened for tobacco and alcohol use among those registered (Average of all facilities compared to individual facilities) (Aug 2014- Mar 2015)



The evaluation also measured the percentage of pregnant women who were assessed for tobacco use by the health care provider and who took an express urine cotinine test during their first prenatal visit and of those who tested positive for tobacco use, received a brief physician intervention counseling for quitting smoking during their pregnancy.

According to patient records, during the implementation period, 90% of pregnant smokers and 74% of pregnant women who admitted to drinking any alcohol received the BPI intervention. This was corroborated by the patient survey, in which 95% of smokers who came to the clinic because of expected pregnancy said that their doctor advised them to quit smoking, and 91% of drinkers who came to the clinic because of expected pregnancy said that their doctor advised them to quit drinking alcohol, both higher than the pre-intervention values of 83% (p=0.1) and 75% (p=0.008), respectively. Further, at end line, 94% of smoking women who came to the clinic because of expected pregnancy said the doctor explained to them how to reach the goal and about possible difficulties the woman would face, up from 83% at baseline. Some 93% of women who came because of expected pregnancy and drank alcohol said the doctor explained how to reach the goal compared to 75% in the first cohort.

Likewise, 92% of pregnant women received information about family planning during the BPI implementation period. This was corroborated by a patient survey, in which 92% of reproductive age women indicated that they discussed the use contraceptives with their doctor, a statistically significant increase from the baseline period when 82% of women reported that they discussed family planning. **Figure 2** shows an increase in the percentage of pregnant women receiving the BPI intervention among those who were tested cotinine positive at their first visit. Definitions and values of indicators, numerators and denominators presented in Figure 2 are provided in **Table 12**.

Figure 2. Percentage of pregnant women receiving BPI intervention among those who test cotinine positive at their first consultation

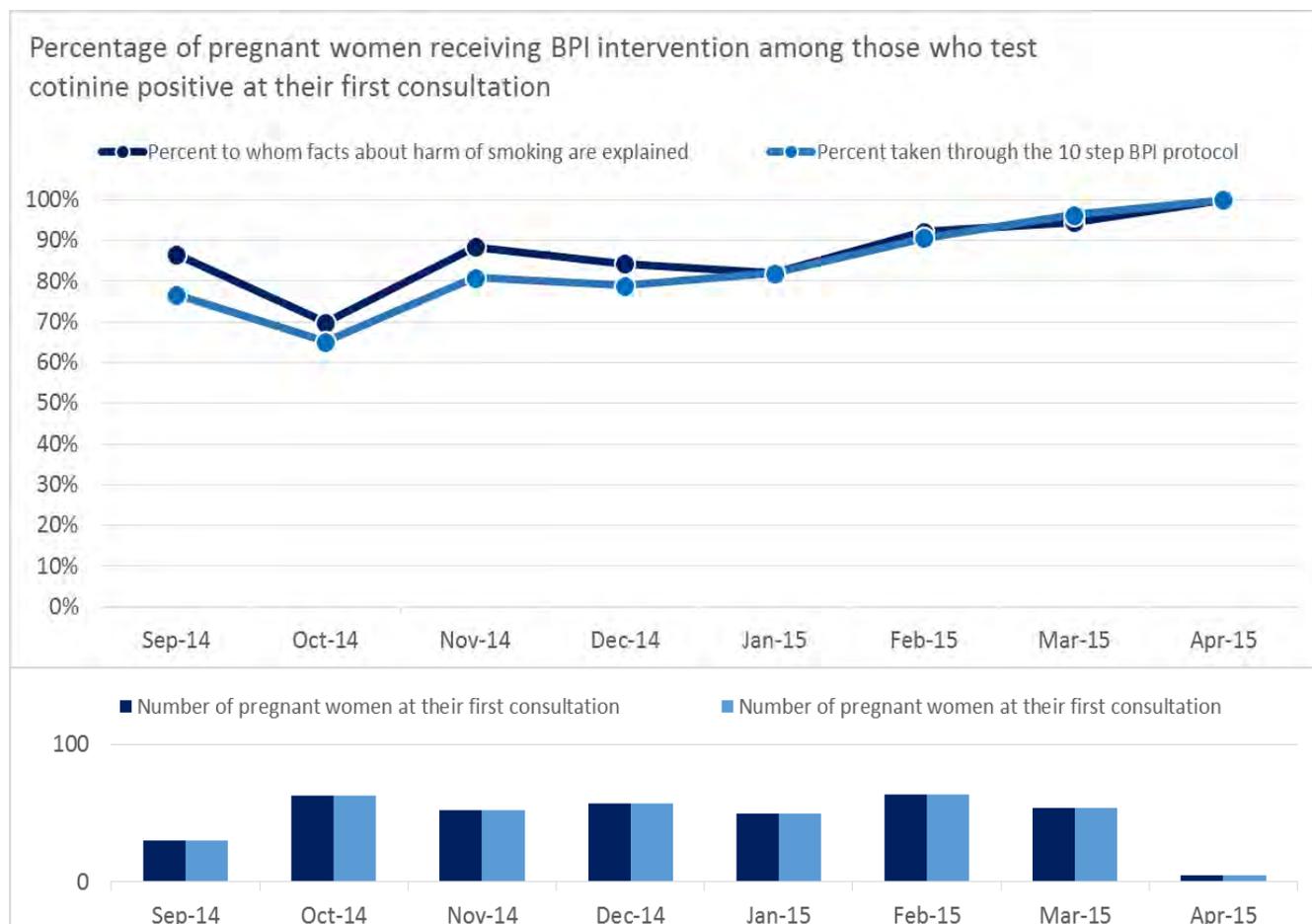


Table 11. Definitions of indicators, numerators, and denominators

Definitions	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Percent of pregnant women to whom facts about harm of smoking explained (indicator 1)	87	70	88	84	82	92	94	100
Number of women to whom facts about smoking explained	26	44	46	48	41	59	51	5
Number of pregnant women at their first consultation who test cotinine-positive	30	63	52	57	50	64	54	5
Percent of pregnant women who received BPI counseling (indicator 2)	77	65	81	79	82	91	96	100
Number of women who received BPI counseling	23	41	42	45	41	58	52	5
Number of pregnant who test cotinine-positive at their first consultation	30	63	52	57	50	64	54	5

IV. DISCUSSION

Results from the assessment study revealed that the immediate quit rate for smoking among the cohort of pregnant women pre-intervention (49%) was actually higher than those post-intervention (22%). In addition, similar rates of reduction in alcohol consumption were observed in the pre-intervention cohort and post-intervention cohort. The lack of improvement in pre-and post-intervention tobacco and alcohol usage rates among pregnant women was likely due to the political and economic instability—in particular the rapidly increasing inflation in Ukraine over the study period.

During data collection for Cohort 1 (June-early September 2014), inflation rose by between 10% and 15% per month (**Figure 3**). During data collection for Cohort 2 (late September 2014 to April 2015), inflation rose from over 15% to 46% per month, just under the accepted definition of “hyperinflation” of 50% per month [15], which Ukraine subsequently reached in May 2015. It is difficult to determine whether or not inflation caused the decrease in smoking prevalence among pregnant women from 19% in Cohort 1 to 13% in Cohort 2 (32% reduction). Under normal circumstances, the price of cigarettes would be expected to cause only modest reductions in cigarette consumption. According to the estimated price elasticity of demand for cigarettes in Ukraine of -0.4 [16], an 80% price increase would be expected to result in a 32% reduction in cigarette demand but it is not known if elasticity is linear at such high levels of price increases. Also, this elasticity of cigarette demand predicts how much smokers would reduce smoking, not whether or not they would quit.

The target of providing BPI counseling to at least 80% of pregnant women who screened positive for tobacco use in all pilot facilities was reached on average (90%). During the implementation period, 74% of pregnant women who admitted alcohol use during their first antenatal visit received BPI, slightly below the 80% target.

However, the data indicated that, from the patient’s perspective, physicians were more likely to ask women about smoking and alcohol use and more likely to advise pregnant women who smoke or drink alcohol to stop after the BPI training. These data suggest that the processes of providing information and advice on alcohol and tobacco use to patients—particularly counseling on the effects of tobacco and smoking—improved after the BPI training, which was a key goal of the project implementation.

Figure 3. Ukraine inflation rate (January 2014-June 2015)



The project faced a variety of technical and contextual challenges ranging from the lack of appreciation of preventive counseling by obstetrician-gynecologists to the absence of registration in Ukraine and therefore availability of biochemical tests (urine dipsticks) to validate tobacco smoking. The rapid deterioration of political and economic stability that started in Ukraine in January 2014 and further escalated in Eastern Ukraine significantly affected the project design, and most importantly, the timeline of implementation. Despite this influence, the project demonstrated substantial achievements and produced considerable insights to inform planning of future initiatives on how to integrate new content of care into clinical practice procedures for patients at high risk from smoking and alcohol use.

The time frame of the project has special significance. Although it was demonstrated that the coverage of pregnant women with BPI counselling was improved during September 2014 – April 2015 period, more time would have been needed to ensure that providers improved their counseling skills and to evaluate results of follow-up of patients who received counseling. Published evaluations inform that although many patients quit for a few weeks after the first visit, they relapse within 45-60 days [12, 21]. The "quit rate" for this activity was an "immediate quit rate" and should not be compared to the results of published meta-analyses of the effectiveness of BPI methods.

V. RECOMMENDATIONS AND WAY FORWARD

The growing evidence about prevalence of smoking and use of alcohol during pregnancy in Ukraine requires immediate attention and concerted efforts to raise awareness among childbearing women, adolescent girls, their families, and Ukrainian health care providers about the risks associated with the health of future mothers and their babies, and the availability of modern, evidence-based counseling techniques, such as BPI, to prevent these risks. The introduction of the BPI protocol in Ukraine was shown to be feasible for use in primary care settings and should be integrated into routine care so that every patient who needs it, receives it.

The use of process improvement indicators should be promoted by regional and national level health authorities to determine whether high-quality care is delivered to every patient, every time.

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APPENDICES

Appendix A: List of Participating Facilities in Poltava Oblast

#	Name of the Polyclinic of Women's Health	Address	Number of specialists including obstetricians and gynecologists in the implementation team
1	Polyclinic of Women's Health, Poltava Clinical Maternity House	Poltava, Engelsa str., 27-b	16
2	Polyclinic of Women's Health, 4 th Poltava City Clinical Hospital	Poltava, Kalinina str., 36	15
3	Polyclinic of Women's Health #1, Kremenchug City Maternity House	Kremenchug, Tsurupy str., 20/3	8
4	Polyclinic of Women's Health #2, Kremenchug City Maternity House	Kremenchug, Kiev str., 14	9
5	Polyclinic of Women's Health, City Hospital #2	Kremenchug, Gen. Managarov str.,7	5
6	Polyclinic of Women's Health, Komsomolsk City Hospital	Komsomolsk, Mira str., 10	6
7	Polyclinic of Women's Health, Poltava Central Regional Hospital	Poltava, Komsomolska str., 58-a	8
8	Polyclinic of Women's Health, Lubensky Communal City Hospital	Lubny, Lva Tolstogo str., 18-a	7
9	Polyclinic of Women's Health, Mirgorod Central Regional Hospital	Mirgorod, Gogolya str. 149-a	6
	Total		80

Appendix B: Patient Screening Form (First Visit)

Questionnaire 1 – First Visit - № _____

A screening and consulting form on tobacco and alcohol use for women of reproductive age

1. **Date of the survey** DD/MM/YY __ __ / __ __ / 1 5
2. **Clinic ID:** Poltava
3. **Doctor's ID:** Poltava (from 1 to 85)
4. **Patient's medical record number:** _____
5. **Patient's age** (in years – two-digit number):
6. **How many children do you have?** 0 1 2 3 4 5 and >
7. **Pregnancy:** Yes No
8. **The number of a gestation week, if pregnant** (two-digit number from 1 to 45):
9. **Marital status (×):** married , single , civil marriage , widowed
10. **Education (×):** incomplete secondary , secondary , special secondary ,
incomplete higher , master/higher
11. **Cotinine test (×):** Yes No Refusal **Result:** «+» , «-»
12. **Do you smoke cigarettes?** (tobacco, e-cigarettes, hookah...)?
Yes No Never used tobacco products
13. **How many smokers do live with you?** (choose one option with a circle)
0 1 2 3 or more
14. **What smoking practice is there in a place where you live?**
Nobody smokes in the premises I live in
There are specific smoking rooms in the premises I live in
You can smoke anywhere in my place of residence
15. **How many smokers are there among your friends and relatives?** (choose only one option):
None Some Half Majority
16. **How soon after you wake up do you usually smoke or use tobacco?** (choose only one option with a circle)
5 minutes or less 6-30 minutes 31 – 59 minutes
1 -2 hours More than 2 hours
17. **In your opinion, how harmful are tobacco products for you** (cigarettes, cigars, pipe tobacco, e-cigarettes, hookah or smoke-free tobacco (chewing tobacco, snuff tobacco, dissolvable tobacco))? (choose only one option with a circle)
Non-harmful 1 2 3 4 5 6 7 8 9 10 **Very harmful**
18. **In your opinion, how harmful for you and your fetus is tobacco used by you and your environment** (cigarettes, cigars, pipe tobacco, e-cigarettes, hookah or smoke-free tobacco (chewing tobacco, snuff tobacco, dissolvable tobacco))?
Non-harmful 1 2 3 4 5 6 7 8 9 10 **Very harmful**
19. **How much are you sure that you can quit smoking during your pregnancy?**
Not sure 1 2 3 4 5 6 7 8 9 10 **Extremely sure**
20. **How many days a week have you drink alcohol for the last 3 months?**
0 1 2 3 4 5 6 7
21. **When you drink, usually, how many standard drinks would you have had in a day?**
Insert a number
22. **How many drinking days with 5 or more standard drinks a day did you have in the last 3 months?**
Insert a number
23. **Do you believe that a pregnant may drink, but not abuse alcohol?** (circle only one answer)
Completely agree 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

24. Do you believe that drinking beer or red wine during pregnancy may benefit or harm the baby? (choose only one option with a circle)
 May bring many benefits 1 2 3 4 5 6 7 8 9 10 May bring a lot of harm
25. How much are you sure that you can quit using alcohol during your pregnancy (if you are pregnant)/reduce (if you're planning your pregnancy)? (choose only one option with a circle)
 Not sure 1 2 3 4 5 6 7 8 9 10 Extremely sure

If a patient smokes or uses alcohol, skip to “5A” BPI.

Please, tick all the steps of the “5A” protocol you've managed to implement. This part of the questionnaire should be used by a doctor for self-control over the protocol implementation and it can't serve as a tool for setting fine penalties against a doctor.

	Tobacco	Yes	No	Alcohol	Yes	No
ASK	Permission to consult			Whether a patient uses contraceptives or plans her pregnancy (already pregnant)		
	Number cigarette smoked per day			Permission to consult		
				Questions on the alcohol use (questions on dosage, AUDIT, TACE)		
ASSESS	Facts of tobacco impact on mother's and fetus' help			Provide feedback on alcohol use and (not for the pregnant) on the risk/pregnancy occurrence		
	Readiness to quit on the 1 to 10 scale			Provide information (facts) about alcohol risk factors for the fetus/FAS or FASD		
				Readiness to change behavior (alcohol or contraceptives)		
ADVICE	10 Steps Protocol			Advice on importance of the choice: either quit (reduction) alcohol use/or use reliable contraceptives		
	Assistance in selecting the aim			Assistance in making the choice selecting the aim		
ASSIST	“10 steps to quit” guidelines for a patient			Discuss the methods to reach the goal		
	Discuss barriers			Discuss barriers		
	Provide support and readiness to help			Provide support and readiness to help		
	Refer to related services, if necessary			Refer to related services, if necessary		
ARRANGE	Set the next visit			Set the next visit/or refer to		
	Thank for the conversation			Thank for the conversation		

Appendix C: Patient Screening Form (Second Visit)

Questionnaire 2 – Second visit (*copy the number from the Questionnaire №1*) _____

A follow-up visit form after consulting on quitting smoking and alcohol use among WRA

1. Date of the survey DD/MM/YY ___ / ___ / 15
2. Clinic ID: Poltava
3. Doctor's ID:
4. Patient's medical record number: _____
5. Patient's age (in years – two-digit number):
6. Pregnancy: Yes No
7. The number of a gestation week, if pregnant (two-digit number from 1 to 45):
8. Cotinine test (×): Yes No Refusal Result: «+» , «-»
9. Do you smoke cigarettes? (tobacco, e-cigarettes, hookah...)?
Yes No Never used tobacco products

If the answer is “Never used tobacco products”, please, skip to the Question #11.

10. While describing the period since your first visit to a Women's clinic, what of the following would you use? (tick all related options)
 - a. I smoke about the same. The number of cigarettes I smoke daily (CPD)
 - b. I smoke, but I've reduced the CPD number. My CPD value
 - c. I've started smoking/started smoking more. My CPD value
 - d. I sniff, chew or use dissolvable tobacco. UPD value (Uses per day)
 - e. I've quit smoking! (yes/no)
 - f. How many days has it been since your last cigarette? (insert the value)
11. Have there been any changes in the smoking environment you live in?
(please, tick all related options)
No changes
Nobody smokes inside in a place I live in – they all smoky outside
I started smoking /started smoking more after I've found out about pregnancy
You can smoke anywhere in my place of residence
There are specific smoking rooms in the premises I live in
12. How much are you sure that you can quit smoking during your pregnancy? (choose only one – answer with a circle)
Not sure 1 2 3 4 5 6 7 8 9 10 Extremely sure
13. How much support did your Family and friends give to you to quit smoking?
Not supportive 1 2 3 4 5 6 7 8 9 10 Very supportive to quit
14. Have your doctor provided you with anything from below since the moment of your consulting on quitting smoking? (selected only the tools you were provided with)
I haven't been provided with any information
My doctor has been consulting me on quitting “Since the beginning”
I've been provided with “10 steps to quit smoking”
My doctor called me on the day I had to quit
15. What were your average weekly rates of alcohol use for the last 3 months?
(select only one answer with a circle)
0 1 2 3 4 5 6 7

16. **When you drink, usually, how many standard drinks would you have had in a day?**
Insert a number (the answer can be 0)
17. **How many drinking days with 5 or more standard drinks a day did you have in the last 3 months?** Insert a number (the answer can be 0)
18. **While describing the period since your first visit to a Women's clinic related to alcohol use, what of the following would you use?** (tick all related options)
- I never used alcohol products (yes/no)
- I've been using alcohol about the same Number days a week
- Number standard drinks a day
- Number of days when drink more than 5 standard alcohol drinks
- I use alcohol, but I've reduced the number. The number of standard drinks per day
- I've quit using alcohol!
- How many days have passed since your last drink? (insert the value)
19. **Have your doctor provided you with anything from below since the moment of your consulting on quitting?** (selected only the tools you were provided with)
- I haven't been provided with any information
- My doctor has been consulting me on quitting/reducing "Since the beginning"
- I've been provided with the "Recommendations to Alcohol quitting for reproductive age women"
- I've been set on another follow-up visit
20. **Do you believe that a pregnant may drink, but not abuse alcohol?** (choose only one option with a circle)
- Completely agree 1 2 3 4 5 6 7 8 9 10 Completely disagree**
21. **Do you believe that drinking beer or red wine during pregnancy may benefit or harm the baby?**
(choose only one option with a circle)
- May bring many benefits 1 2 3 4 5 6 7 8 9 10 May bring a lot of harm**
22. **How much are you sure that you can quit during your pregnancy (if you are pregnant)/reduce (if you're planning your pregnancy)?** (choose only one option with a circle)
- Not sure 1 2 3 4 5 6 7 8 9 10 Extremely sure**

Appendix D: Gender Integration Brief

How does gender relate to improvement work in Ukraine?

Males and females face different levels of susceptibility to health concerns based on their genetic makeup as well as on prevailing gender norms that influence behaviors and quality of health services. For example, 46% of women in Ukraine reported alcohol use in the most recent months of pregnancy [17], yet counseling on the reduction of alcohol use during pregnancy is insufficient since health providers don't consider women at risk because these behaviors have been historically associated with men and boys. In addition, exposure to environmental pollutants such as second-hand smoke can negatively impact the health of pregnant women and their unborn children.

Women are also disproportionately affected by environmental pollutants: in Poltava, 49% of women reported that they live or spend time with someone with smoke around them. Globally, roughly 47% of deaths caused by second-hand smoke are in women, while just 26% are in men [14]. Power imbalances can cause women to be less able to negotiate smoke-free spaces in work places, social gatherings, and in their own home. Gender-related power inequalities also have implications for treatment, as women and girls may depend on their husbands or partners for health care decision-making, access, and expenditures. Lack of awareness among women and health care providers of the risk faced by women may negatively affect health-seeking behaviors, prevention, and early detection and treatment of this serious disease.

What is gender integration and why is it important?

Addressing the different needs, behaviors, preferences, access to, and utilization of health services for men, women, girls, and boys is critical to any improvement effort. It is critical that improvement interventions consider gender issues and gender gaps to ensure they equitably reach half of the population and to avoid unintentionally exploiting or harming one sex. From an implementation perspective, addressing gender issues in improvement activities is an efficient use of resources; from a quality improvement standpoint, this encourages patient-centeredness, safety, and equality. Gender issues related to alcohol and tobacco use in pregnant women need to be taken into account when designing, implementing, and evaluating strategies and services.

Gender integration means identifying, and then addressing gender inequalities during strategy and project design, implementation, and monitoring and evaluation of a project. Through the USAID ASSIST Project, we use the science of improvement to identify and then address gender-related gaps to improve health outcomes. Our holistic approach promotes gender integration through contextualized and adaptable methods requiring little or no additional costs to the improvement effort while maximizing benefits. It results in locally-developed solutions, improved country leadership, an expanded partner base with links to other sectors, and institutionalization of gender integration in improvement at all levels of care.

Gender integration efforts in Ukraine

In September 2014, the USAID ASSIST Project conducted research to better understand how gender impacts the project's target health issues (i.e., alcohol and tobacco use and violence during pregnancy). This quantitative survey was developed by Dr. Elena Novichkova, with input from WI-HER LLC. Data was collected from 617 women and girls of reproductive age that attended participating women's health centers in Poltava Oblast. Results from a preliminary analysis were shared with participants at two gender integration trainings and the survey results were utilized during training exercises.

In October 2014, the USAID ASSIST Project conducted two gender integration trainings; nine doctors in Poltava and seven advisors in Kiev were trained. Sessions included defining gender and gender-related concepts, identifying gender issues and gaps (gender analysis), addressing gender issues and gaps (designing changes to test), and analyzing and reporting results (sex-disaggregated data and gender-sensitive indicators).

Recommendations

Based on these trainings and technical assistance on gender integration provided to the project in October 2014, a list of recommendations on how best to integrate gender into the project were proposed. Acknowledging that the USAID ASSIST Project in Ukraine is expected to end in 2015, there are several potential short and long-term activities to integrate gender. Examples of recommendations are presented below.

Short-term

- Sensitize health care providers to different cultural norms that affect health-seeking behaviors, care, and treatment through technical brief or learning sessions
- Raise awareness (e.g., integrate gender-sensitive language into patient materials, develop handouts and talking points for providers to use during counseling sessions) among female patients about the importance of male involvement to reduce drinking or smoking during pregnancy
- Strengthen the capacity of health care providers responsible for non-communicable disease care to identify and respond to gender-related issues in their programs through trainings, and by developing gender-sensitive guidelines and protocols
 - Integrate gender-sensitive language into the academic post-graduate education curriculum
 - Review treatment protocols and guidelines to ensure that gender-related issues are addressed and support their implementation
 - Integrate gender-sensitive language into national protocols and necessary materials
- Select one motivated provider to integrate gender during intervention, such as engaging male partners in ANC visits (outcomes could be measured for two months)
- Develop gender-sensitive indicators that measure male involvement in ANC appointments and track over time
- Express interest in continuing gender integration in reports so partners, including the Ministry of Health and USAID, understand the need and demand to continue this work
- Submit funding requests to USAID or other funders to pursue opportunities to address gender issues within this work.

Long-term

- Conduct a gender analysis and develop comprehensive strategies that consider local barriers that impact alcohol and tobacco use by pregnant women in the community.
- Discuss opportunities to collaborate with local ministries, NGOs, or other partners working on gender to determine how the project can coordinate efforts to address gender disparities affecting relevant health outcomes
- Where possible, advocate for gender-sensitive policies with MOH related to project goals
- Strengthen the capacity of health care providers and systems to make services gender-inclusive and equitable (e.g., increase male participation)
 - Design strategies that encourage men and women to access available health care services (e.g., make women's clinics more male-friendly [for example, there is no men's bathroom in the clinic]; create incentives for males to attend clinic visits [for example, offer free WI-FI])
 - Encourage the same level of responsibility to each parent
 - Integrate intensive gender integration course in academic post-graduate education curriculum
 - Provide incentives to doctors who counsel a certain number of couples
- Raise awareness among the public and educate males and females about risks of tobacco and alcohol use in families with pregnant women and their male partners and related healthy behaviors
- Address the specific disadvantages that women and girls tend to face which cause them to be less likely to access relevant services in certain communities, such as lack of decision-making power.

Appendix E: BPI Training Curriculum Approved by the National Medical Academy of Postgraduate Education

MINISTRY OF HEALTH OF UKRAINE

Shupyk National Medical Academy of Postgraduate Education



“APPROVED”

Shupyk NMAPE

Research Council

Protocol # 07

“17” September 2014

Head of the Research Council

Academic at the NAS of Ukraine,

Professor _____ Voronenko Y.V.

CURRICULUM AND EDUCATION PLAN

Specialized capacity building training for doctors

“USE OF BRIEF PHYSICIAN INTERVENTION TECHNOLOGIES TO DECREASE THE INCIDENCE OF TOBACCO AND ALCOHOL USE AMONG THE PREGNANT AND WOMEN OF REPRODUCTIVE AGE”

Training duration – 0,25 months (39 hours)

Department of Obstetrics, Gynecology and Reproductology

Kyiv – 2014

EXPLANATORY LETTER

to the capacity building training curriculum and education plan

“USE OF BRIEF PHYSICIAN INTERVENTION TECHNOLOGIES TO DECREASE THE INCIDENCE OF TOBACCO AND ALCOHOL USE AMONG THE PREGNANT AND WOMEN OF REPRODUCTIVE AGE”

The education plan and curriculum were drafted with the focus on building theoretical knowledge and practical skills for those experts engaged in implementing activities on decreasing the rates of tobacco and alcohol use among the pregnant and women of reproductive age.

Maternity and childhood protection in Ukraine is a healthcare priority. Its importance is based on both strengthening of physical facilities and human resources capacity and introduction of advanced organizational and medical technologies while working with the pregnant and women of reproductive age, in order to minimize negative impact on the fetus and future neonate.

Harm caused to a human health by tobacco and alcohol abuse is a well-known fact. Their destructive power for the pregnant and women of reproductive age is even stronger. Hence, a set of valid scientific sources proves that smoking during and after pregnancy is related to risk for a fetus and a neonate, including low birth weight, miscarriages, placental abruption, preterm rupture of membranes, sudden infant death syndrome, increased rates of respiratory diseases among children, etc.

Alcohol harm during pregnancy may be also amplified by the Fetal Alcohol Syndrome (FAS).

The aforementioned problems are well known for obstetricians and gynecologists, but there is not enough time for consulting female patients for prevention of this problem by the aforementioned healthcare experts. It is of more importance to build contacts between women of reproductive age and experts of other specialties (first and foremost, general practitioners and family doctors).

This drafted capacity building curriculum is focused on using the brief invention technology to decrease incidence rates of tobacco and alcohol use among the pregnant and women of reproductive age. It covers a wide range of experts acting in the field of fetal medicine, prenatal prevention activities or reproductive healthcare.

The contents of the curriculum cover sufficient volume of knowledge and skills necessary for implementing qualified activities on decreasing incidence rates of tobacco and alcohol use by the pregnant and women of reproductive age.

The curriculum consists of three major sections. Each of them has several subordinate topics.

In order to complete the curriculum, the learning process itself considers lectures, workshops and trainings.

The education plan defines duration and time managed related to the curriculum.

The plan considers 0,25 months (39 hours).

Upon completion of the capacity building training “Use of brief physician intervention technologies to decrease the incidence of tobacco and alcohol use among the pregnant and women of reproductive age”, attendees shall pass a test and acquire a related standard certificate.

EDUCATION PLAN

Duration – 0,25 months (39 hours).

General purpose: augmentation and systematization of theoretical knowledge and practical skills related to brief physician interventions focused on decreasing the rates of alcohol and tobacco use by the pregnant and women of reproductive age.

Cohort: general practitioners – family doctors, medical and prevention specialty doctors at healthcare centers (offices, departments), psychologists, obstetricians and gynecologists (including those working with children and adolescent).

ID	Title	Academic hours number			
		Lecture	Seminar	Practice	Total
01	Management and set up of prevention of risks related to use of psychoactive substances among the pregnant (tobacco, alcohol)	2	4	2	8
02	Brief physician interventions focused on decreasing the rates of alcohol use by the pregnant and women of reproductive age.	4	6	6	16
03	Brief physician interventions focused on decreasing the rates of tobacco use by the pregnant and women of reproductive age.	4	6	4	14
	Test		1		1
	Total	10	17	12	39

CURRICULUM

for the capacity building training “Use of brief physician intervention technologies to decrease the incidence of tobacco and alcohol use by the pregnant and women of reproductive age”

ID	Title
01	Management and set up of prevention of risks related to use of psychoactive substances among the pregnant (tobacco, alcohol).
01.01	Summary of legal and regulatory documents if Ukraine related to family planning and reproductive health.
01.02	QI concept for healthcare service provision.
01.03	Evidence-based prevention activities. Arrangements and working on prevention of risks related to use of psychoactive substances among the pregnant (tobacco, alcohol).
02.	Brief physician interventions focused on decreasing the rates of alcohol use by the pregnant and women of reproductive age.
02.01	Basics of the Fetal Alcohol Spectrum Disorders (FASD). Diagnostics and major clinical signs.
02.02	Screening programs and tools for defining women at risk regarding alcohol use.

ID	Title
02.03	Brief physician interventions in FASD prevention. Basics and algorithm.
02.04	Mastering the brief physician intervention methods.
02.05	Motivational interviewing.
02.06	Protocol of a training of trainers program for training doctors, psychologists and health care specialists working at prevention centers in brief interventions aimed at FASD prevention at a healthcare and prevention facility level.
02.07	Intervention and supervision skills training.
02.07	Working on skills to deliver a training session (practical use of training components).
02.08	Role-playing games in small groups. Skills assessment. Role-play discussion.
03.	Brief physician interventions focused on decreasing the rates of tobacco use by the pregnant and women of reproductive age.
03.01	Prevention of infectious diseases and smoking, as an independent risk factor for women's reproductive health. Smoking incidence rates and trends in 1990 -2013.
03.02	Biomarkers of tobacco intoxication for the pregnant and women of reproductive age. Tobacco addiction and quitting programs for the pregnant.
03.03	Technology for training pregnant patients in the methods to quit smoking. Brief physician interventions to prevent diseases related to tobacco addiction.
03.04	Role-playing game and demonstration of a brief physician intervention for a tobacco-addicted female patient.
03.05	Drilling in BPI skills related to working with tobacco-addicted patients. Role-playing games in small groups.
03.06	Assessment methods for prevention programs based on implementation of brief physician interventions.
03,07	Change management in healthcare service provision focused on the pregnant and women of reproductive age.
03.08	Final control over knowledge, skills and abilities.

LIST OF PRACTICAL SKILLS

No	Skills
1.	Arrange and implement prevention of risks related to alcohol and tobacco impact to the pregnant and women of reproductive age.
2.	Perform a Cotinine test.
3.	Implement a brief physician intervention in quitting the smoking habit.
4.	Implement a brief physician intervention in quitting alcohol use among the pregnant.
5.	Develop a patient oriented plan of quitting, decreasing/refusing from alcohol.

Appendix F: Job Aids for Doctors and Patient Materials in Ukrainian

F1: Doctor's Guide to the Brief Physician Intervention

The 32-page guide explains all of the steps in the brief physician intervention as well as the counseling tools. The second image is of one of the counseling tools included in the guide—the counseling card showing the standard dose of alcohol.

Технологія профілактичних короткострокових втручань лікаря для зниження розповсюдженості тютюнокуріння і вживання алкоголю жінками репродуктивного віку і вагітними

1 СТАНДАРТНА ДОЗА = **10** Г АБС. ЕТИЛОВОГО СПИРТУ

Доза алкоголю в напої залежить від кількості чистого спирту (градуса) в напої, тобто його міцності, та об'єму пляшки (або банки).

 330 мл пива міцністю 3,5 - 5%	 1 літр пива (~ 3,5 - 5%) містить 3 стандартні дози алкоголю
 1 бокал столового вина 100 мл міцністю 11,5 - 13%	 1 пляшка столового вина (750 мл - ~11,5 - 13%) - 7 доз алкоголю
 1 чарка 30 мл спиртних напоїв міцністю 40%	 1 пляшка горілки (500 мл-40%) - 17 доз алкоголю

F2: Pocket card for doctor with short audit WHO test to assess alcohol use by patient

The front side is the test itself, and the back side guides the physician in interpreting patient answers.



Проект з удосконалення сфери охорони здоров'я

ТЕСТ «АУДИТ» коротка версія

Для того, щоби забезпечити жінок інформацією про шкочу споживання алкоголю під час вагітності, важливо знати, скільки жінка вживає алкоголю, і наскільки ситуація змінилась від того часу, як вона дізналась про свою вагітність. Така оцінка споживання алкоголю у поєднанні з освітою і підтримкою, може допомогти жінкам припинити вживати алкоголь взагалі або принаймні зменшити рівень його вживання під час вагітності. Це надає змогу попередити такі незворотні наслідки від вживання алкоголю для дитини, як Фетальний алкогольний спектр порушень (ФАСП).

Одним з ефективних та простих методів оцінки вживання алкоголю жінкою, не виносячи при цьому жодних суджень, вважається ТЕСТ «Аудит», який складається з 10 питань, було розроблено Міжнародною організацією охорони здоров'я в 1989 році. Його коротка версія складається з трьох запитань. Загальна кількість балів у відповідях вказує на ризики для здоров'я жінки, і також може використовуватись для рекомендацій під час розмови про алкоголь і вагітність. Проте для жінок найбільш безпечним буде відмова від вживання алкоголю під час вагітності взагалі.

ТЕСТ «Аудит» коротка версія: запитання

Додайте бали по кожному із запитань, щоби отримати остаточний результат і порівняти його зі значеннями ризику на звороті.

Питання	Система оцінювання					Бал
	0	1	2	3	4	
Як часто Ви п'єте алкогольні напої?	Ніколи	Раз на місяць чи менше	2-4 рази на місяць	2-3 рази на тиждень	4+ рази на тиждень	
Скільки стандартних доз алкоголю Ви випиваєте в типовий день, коли його вживаєте (коли не були вагітні чи взагалі)?	1-2	3-4	5-6	7-9	10+	
Як часто Ви випиваєте 5 і більше ст. доз алкоголю за один раз?	Ніколи	Менше разу на місяць	Щомісяця	Щотижня	Щодня чи майже щодня	

Стандартна доза – це міра вживання алкоголю, яка вважається більш надійним рахувати стандартні дози алкоголю, ніж склянки, пляшки чи банки, тому що алкоголь може подаватись в різній тарі. Стандартна доза алкоголю для України становить 10 грам (еквівалент 12,5 мл чистого спирту). Наприклад:

- 100 мл склянка червоного чи білого вина при 11.5 - 13% об'ємного вмісту спирту = 1 ст. доза алкоголю
- 330 мл пляшка чи банка пива при 3.0 – 3.5% об'ємного вмісту спирту = 1 ст. доза алкоголю
- 30 мл чарка міцного спиртного напою при 40% об'ємного вмісту спирту = 1 ст. доза алкоголю
- 330 мл пляшка готового до вживання напою при 5% об'ємного вмісту спирту = 1.2 ст. доз алкоголю

Підготовлено в рамках Проекту з удосконалення сфери охорони здоров'я (НС) - «Вдосконалення контролю над вживанням алкоголю і тютюнопалінням під час вагітності в Україні», який фінансується Агентством США з міжнародного розвитку (USAID). Зміст публікації не обов'язково відображає точку зору USAID або Уряду США.

Бали	«Аудит» коротка версія: можливі поради після підрахунку балів
0 – 3 = низький ризик	<ul style="list-style-type: none"> • Надати позитивний сигнал, якщо в пацієнтки нуль балів, а також заохотити її не повертатись до алкоголю під час вагітності. Нуль балів вказує на відсутність ризику для плоду. • Якщо пацієнтка набирає від 0 до 3, порадьте їй, що ризик для її плоду лишається незначним, але безпечніше було б взагалі відмовитись від алкоголю під час всієї вагітності. • Поясніть їй, що ризик для плоду в стані розвитку буде зростати зі збільшенням кількості і частоти вживання алкоголю, а також повідомте її про те, що будь-який бал вище нуля несе потенційний ризик для плоду. • Заохочуйте її до повної відмови від алкоголю під час вагітності і призначте наступну зустріч для подальшого нагляду, якщо існує така потреба.
4 – 7 = середній ризик	<ul style="list-style-type: none"> • Порадьте їй, що найбезпечніше було б взагалі не вживати алкоголю під час вагітності. • Поясніть їй, що такі бали АУДИТУ вказують на те, що вона вживає алкоголь з наростаючим ризиком для свого здоров'я, а якщо вона набирає більше 5 балів, то і для здоров'я дитини. • Поясніть їй, що ризик для плоду в стані розвитку буде зростати зі збільшенням кількості і частоти вживання алкоголю. • Обговоріть з нею вплив поточного рівня вживання алкоголю і підкресліть можливі проблеми для її власного здоров'я і здоров'я її дитини. • Підкресліть переваги відмови від алкоголю на будь-якому етапі вагітності задля мінімізації подальшого ризику для неї і її дитини. • Запитайте в неї, як вона почувається з приводу того, щоби відмовитись від алкоголю або зменшити рівень його вживання і встановіть: <ul style="list-style-type: none"> – Позитивні і негативні сторони активних дій – Рівень її впевненості в спроможності кинути чи зменшити рівень вживання – Поради, стратегії і плани діяльності – Чи потрібна їй підтримка, включаючи підтримку від мереж довіри і партнерів – Запропонуйте їй направлення, якщо вона вважає, що їй така підтримка потрібна • Якщо у Вас є підозри на алкогольну залежність, організуйте їй направлення до спеціалізованого закладу чи служби.
8+ = високий ризик	<ul style="list-style-type: none"> • Поясніть їй, що такі бали АУДИТУ вказують на те, що від такого вживання алкоголю існує високий ризик для її власного здоров'я і здоров'я її дитини. • Обговоріть з нею позитивні і негативні сторони активних дій, а також визначте, яка підтримка їй потрібна, щоби відмовитись від алкоголю або зменшити рівень його вживання. • Направте її до спеціалізованого закладу або служби, так як вона може перебувати в групі ризику алкогольної залежності. Перед тим, як пропонувати їй відмовитись від алкоголю або зменшити рівень його вживання, пацієнтка має отримати спеціалізовану підтримку, так як без неї відмова алкоголю може зашкодити, як їй, так і її дитині.

1. Наказ МОЗ України №339 від 28.11.97 «Про вдосконалення системи профілактичних протиалкогольних та проти наркотичних заходів та обов'язкових профілактичних наркологічних оглядів».
2. F.F. Babor, J.C. Higgins-Biddle. Brief Intervention for Hazardous and Harmful Drinking. A Manual for use in Primary Care. WHO, 2001.
3. Australian guideline to reduce health risks from drinking alcohol. National Health and Medical Research Council's (NHMRC), 2009.
4. Centers for Disease Control and Prevention. Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices. Atlanta, Georgia: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014.

F3: Pocket card for doctor with the BPI protocol

The front side contains the BPI protocol to counsel women to quit using alcohol and the back side contains the BPI protocol to counsel women to quit smoking, both based on the “Five A’s”.



КОРОТКОСТРОКОВЕ ВТРУЧАННЯ ЛІКАРЯ (ЗОНДО) З ПИТАНЬ ТЮТЮНОКУРІННЯ

Основні кроки консультування лікаря:
Запитати – Оцінити – Надати пораду – Допомогти – Організувати

- 1 КРОК** **ЗАПИТАТИ** кожну пацієнтку, чи вона курить
Оцініть скільки сигарет вкурює жінка за день та скільки років курить
- 2 КРОК** **ОЦІНИТИ** бажання здієзнати спробу відмовитися від тютюнокуріння та рівень нікотинової залежності
Можна застосувати одну з методик оцінки залежності, наприклад, Тест оцінки залежності від нікотину (тест Фегерстрема/ Fagerstrom test)
Надайте інформацію/факти про вплив тютюну і отримайте зворотний зв'язок - «вислухати заради зміни» - тобто, почути власні слова пацієнтки на підтримку змін.

Оцініть готовність змінити поведінку:

1	2	3	4	5	6	7	8	9	10
Важко наготова					Легко наготова				

- 3 КРОК** **Надати ПОРАДУ** і допомогти встановити **МЕТУ**: життя без тютюну
Дайте **пораду**: всім курцям відмовитися від куріння
Допоможіть встановити мету
Якщо пацієнтка не готова змінити свою поведінку, не наполягайте на встановленні мети. Запитайте: «Як би Ви почувалися, якби Ваша дитина народилася недоношеною, хворою? Підтримайте кроки в потрібному напрямку і повторіть Вашу пораду, запропонувавши допомоги, коли знадобиться (не переходьте до 4)»
- 4 КРОК** **ДОПОМОГТИ** безпосередньо та/або направити до відповідних служб
Обговоріть способи досягнення обраної мети і допоможіть, слухайте про можливі перепони і засвідчіть свою готовність допомогти (якщо треба, призначте консультацію, дайте направлення до спеціаліста тощо). За необхідності, запитайте про **план відмови**. «Як Ви це зробите? Хто Вам допоможе? Що може завадити?»
- 5 КРОК** **ОРГАНІЗУВАТИ** спостереження і підтримку для пацієнтки, яка хоче відмовитися від куріння
На наступному прийомі оцініть зміни поведінки
Закріпіть успіх і/або запропонуйте допомоги у випадку невдачі
Завжди дякуйте пацієнту за розмову з Вами

1. Відповідно до наказу МОЗ України від 26.09.2012 №746 «коротка програма втручання має назву ЗОНДО».
2. Smoking cessation during pregnancy. A clinician's guide to helping pregnant women quit smoking. The American college of obstetricians and gynecologists, 2011.
3. Відповідно до наказу МОЗ України від 03.08.2012 №601 щодо адаптованих клінічних настанов «Первинна медична допомога при припиненні вживання тютюнової виробки», с. 23.



КОРОТКОСТРОКОВЕ ВТРУЧАННЯ ЛІКАРЯ (ЗОНДО) З ПИТАНЬ АЛКОГОЛЮ

Основні кроки консультування лікаря:
Запитати – Оцінити – Надати пораду – Допомогти – Організувати

- 1 КРОК** **ЗАПИТАТИ** кожну пацієнтку, чи вона вживає алкоголь, чи використовує контрацепцію
Оцініть контрацепцію і вживання алкоголю
Можна додатково застосувати одну з методик скринінгу вживання алкоголю (АУДИТ, TACE або TWEAK)
- 2 КРОК** **ОЦІНИТИ** бажання відмовитися від алкоголю під час вагітності, планування вагітності або недостатньої контрацепції
Надайте інформацію/факти про вплив алкоголю і отримайте зворотний зв'язок - «вислухати заради зміни» - тобто почути власні слова пацієнтки на підтримку змін

Оцініть готовність змінити поведінку:

1	2	3	4	5	6	7	8	9	10
Важко наготова					Легко наготова				

- 3 КРОК** **Надати ПОРАДУ** і допомогти встановити **МЕТУ**: вагітність без алкоголю або надійна контрацепція
Дайте **пораду**: Якщо ризику немає, підтримайте правильну поведінку
Якщо ризик для плоду або жінки є, обговоріть зміни поведінки: зменшення вживання/утримання від алкоголю і/або контрацепцію
Допоможіть встановити мету
Якщо пацієнтка не готова змінити свою поведінку, не наполягайте на встановленні мети. Запитайте: «Як би Ви почувалися, якби Ваша дитина народилася із ФАСП?»
Підтримайте кроки в потрібному напрямку і повторіть Вашу пораду, запропонувавши допомоги, коли знадобиться (не переходьте до 4)»
- 4 КРОК** **ДОПОМОГТИ** безпосередньо та/або направити до відповідних служб
Обговоріть способи досягнення обраної мети і допоможіть (наприклад, з контрацепцією, якщо мета – контрацепція; або обговоріть, як зменшити об'єм вживаемого алкоголю), слухайте про можливі перепони і засвідчіть свою готовність допомогти (якщо треба, призначте консультацію, дайте направлення до спеціаліста тощо). За необхідності, запитайте про **план відмови**. «Як Ви це зробите? Хто Вам допоможе? Що може завадити?»
- 5 КРОК** **ОРГАНІЗУВАТИ** спостереження і підтримку для пацієнтки, яка збирається відмовитися від алкоголю
На наступному прийомі оцініть зміни поведінки
Закріпіть успіх і/або запропонуйте допомоги у випадку невдачі
Завжди дякуйте пацієнту за розмову з Вами

1. Наказ МОЗ України №279 від 28.11.97 «Про вдосконалення системи профілактичних протиалкогольних та проти наркотичних заходів на об'єктах профілактичних наркологічних закладів»
2. F.F. Baber, J.C. Virginia-Bibbels. Brief Intervention for Hazardous and Harmful Drinking. A Manual for use in Primary Care. WHO, 2001.
3. Centers for Disease Control and Prevention. Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices. Atlanta, Georgia: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, 2014.
Підготовлено в рамках Проєкту з удосконалення сфери охорони здоров'я (НДО) - «Вдосконалення контролю над вживанням алкоголю і споживанням під час вагітності» в Україні, який фінансується Агентством США з міжнародного розвитку (USAID). Зміст публікації не обов'язково відображає точку зору USAID або Уряду США.

F4. Workbook for pregnant women

This 52-page booklet was given to each pregnant woman. The first 21 pages contain her medical record, since it is standard practice in Ukraine to provide a duplicate record to be kept by the pregnant woman in case of emergencies. After the medical records portion is filled in by doctor, the remainder of the booklet contains recommendations for the pregnant woman on quitting tobacco and alcohol use.



 **USAID**
ВІД АМЕРИКАНСЬКОГО НАРОДУ

Проект з
удосконалення сфери
охорони здоров'я

Щоденник вагітної

Прізвище _____

Ім'я, по-батькові _____

Домашня адреса _____

Телефон _____ Дільниця _____

*Відповідальна мати –
здорова дитина!*

F5: Wall poster with recommendations to quit tobacco use during pregnancy



Проект з удосконалення сфери охорони здоров'я

Профілактика розповсюдженості тютюнокуріння жінками репродуктивного віку і вагітними

Відповідальна родина – здорова дитина!

Ми розробили спеціальну консультативну програму для родин, які хочуть припинити цю небезпечну звичку

10 КРОКІВ ДО ВІДМОВИ ВІД ТЮТЮНОКУРІННЯ

10 КРОК
Відзнака за відмову!

9 КРОК
Вмотивуйте себе самі

8 КРОК
Допомога – підтримка сім'ї і друзів

7 КРОК
Підписання Угоди з Помічником

6 КРОК
Помічник у відмові від тютюнокуріння

5 КРОК
Практика Глибокого дихання - Йога

4 КРОК
Заплановане зменшення кількості сигарет на день

1 КРОК
«Чому Я маю припинити курити?»

2 КРОК
Мій день відмови: _____ ?

3 КРОК
Щоденник вагітної

10 КРОК
Доказові дані з тютюнокуріння

Вмотивуйте себе самі
Світ мій, дзеркальце, скажи: Чи справді я вірю в те, що куріння шкодить, а відмова від куріння допоможе здоровою моєї дитині?

Допомога – підтримка сім'ї і друзів
Це нормально, якщо Ви попросите Вашу сім'ю чи друзів не курити у Вашій присутності. Скажіть їм, що це важливо для Вас, і що пасивне куріння може сильно шкодити Вашій дитині.

Підписання Угоди з Помічником
Двачі жінки гадають, що їх будуть осуджувати, якщо вони скажуть, що курять. Але завдання лікаря допомогти Вам почуватись зручно і допомогти досягти Вашої мети у відмові від куріння. Для лікаря важливо відкрито обговорити проблему куріння з Вами.

Помічник у відмові від тютюнокуріння
Оберіть будь-кого, з ким Вам зручно, але Помічник не може бути курцем!

Практика Глибокого дихання - Йога
1. Сядьте в зручній позі. Зніміть взуття.
2. Закрийте очі. Розслабте плечі.
3. Глибоко і повільно ВДИХНІТЬ носом, повільно рахуючи до 5 чи 10.
4. Повільно ВИДІХНІТЬ повітря ротом, повільно рахуючи до 5 чи 10.
5. Повторіть ці кроки 10 разів. Дихайте вільно.
6. Так само робіть будь-які та будь-які, щоб перебороти тягу!

Заплановане зменшення кількості сигарет на день
Якщо Ви курите < 20 сигарет на день, Вам слід скорочувати норму на 2 сигарети щодня.
Якщо Ви курите > 30 сигарет щодня, Вам слід скорочувати кількість сигарет хоча б на 3 щодня.

Глици огади – його можна зробити, поклавши недопалики в теплу воду.

F6: Wall poster with recommendations to quit alcohol use during pregnancy



Профілактика вживання алкоголю жінками репродуктивного віку і вагітними

Відповідальна родина – здорова дитина!



Ми чекаємо на дитину або плануємо вагітність



Ми не плануємо вагітність



Безпечних періодів щодо вживання алкоголю під час вагітності не існує! Ураження ембріону під час перших двох тижнів його розвитку призводять до його загибки та переривання вагітності. Ураження протягом наступних тижнів вагітності призводять до різного ступеня уражень відповідних органів і систем.

Критичні періоди розвитку плода



Під час вагітності або планування вагітності: повна відмова від вживання будь-яких алкогольних напоїв – гарантована відсутність у дитини фетального алкогольного спектру порушень (ФАСП) (психологічних, неврологічних, фізичних вад, спрощених вживаннями алкоголю матері).

Фетальний алкогольний синдром (ФАС) характеризується:

1. Дефіцит росту і (або) маси при народженні;
 2. Характерними особливостями будови обличчя (коротка очна щільна, згладжений носогубний жолобок, тонка верхня губа);
 3. Ураження або порушення функцій головного мозку (структурні зміни, неврологічні ознаки або похилий порушення різного ступеня, що проявляються зменшенням пам'яті, сприйняття, порушеннями мови, інтелекту та поведінки).
- ФАС стає помітним після народження дитини та є пожиттєвим станом, що не менше з віком. В термінальний час вважається, що від 2 до 4% дітей, які народилися в Європі, мають порушення фетального алкогольного спектру. Це більше дітей, ніж народжується з синдромом Дауна.

Як відмовити, коли вагітні пропонують випити?

Коли жінка вагітна, а хтось пропонує їй випити, знайдіть достойну відповідь, фразу має звучати твердо та переконливо: Сьогодні, наразі!

- Ні, дякую. Вагітним пити не можна, а не пію.
- Ні, дякую, мій малюк ще дуже малий, щоб пити вино...
- (Пиво, крапту та ін.)
- Дякую! Ми з дитинкою із завдованим випитою мінеральною водою або чаю.
- Я їм за двох, а не пію.
- Ні, сьогодні вино або пиво можуть нашкодити моїй дитині.

- Або:
- П'яні люди рідко обмежують себе з алкоголем.
 - Мені ще, мабуть, шпунок. Я не пію.
 - Я зараз полюбую (випиваю), коли пію менше.
 - Я вирішила кинути.
 - Не хочу ризикувати своїм здоров'ям та здоров'ям свого малюка.

П'яному відмови проба називається втепеною, тоді вона буде грати переважно і наші це розуміють. Треба вміло прокувати та наважуватися на відмову від алкоголю у тих місцях, де її можуть загрозувати.

Як попередити вживання алкоголю під час вагітності?

- Відмовтеся від алкоголю, якщо вирішили спати батьками – полюбите здорове майбутнє вашою малюку.
- Майте на увазі, якщо жінка вагітна, дитина «тїє» теж саме, що і вона – алкоголь з її крові вільно проникає крізь плаценту до плоду.
- Пам'ятайте, що алкоголь шкідливий для плоду в будь-якій кількості.
- Зверніть увагу, що алкоголь шкідливий в будь-який термін вагітності навіть люди, які жінка ще сама не знає, що вагітна.
- Тримайтеся подаль від місць, де п'ють, або від людей, які можуть викласти вас випити.
- Не приймайте алкоголь вдома.
- Якщо вам пропонують випити, відмовтеся.
- Скажіть відмовити сарди оточених та близьких людей, просить про допомогу, шукайте об'єктивне.
- Спитайте поради у вашого лікаря.

Запитайте свого лікаря, який з надійних методів контрацепції Вам підходить?

1. Бар'єрна контрацепція
2. Гормональна контрацепція
3. Внутрішньоматочові контрацептиви
4. Добровільна хірургічна стерилізація

Під час недостатньої контрацепції: вживання алкогольних напоїв – ризик виникнення ФАСП або ФАС (фетального алкогольного синдрому) у дитини, яка може бути зачата

Вживайте алкоголь розумно! Якщо Ви використовуєте контрацепцію, вживайте не більше рекомендованих доз алкоголю за раз/день.

Для здорових жінок віком 21 року і старші

- Не більше 3 стандартних доз за один раз (4 та більше вживаних стандартних доз протягом 2 годин вважається «надмірним» вживанням алкоголю)
- та не більше 7 доз на тиждень.

3 стандартні дози містяться в: 1 літрі пива, 300 мл столового вина, 90 мл горілки чи коньяку.

Для здорових чоловіків віком 21 року і старші

- Не більше 4 стандартних доз за один раз (5 та більше вживаних стандартних доз протягом 2 годин вважається «надмірним» вживанням алкоголю)
- та не більше 14 доз на тиждень.

4 стандартні дози містяться в: 1320 мл пива, 400 мл столового вина, 120 мл горілки чи коньяку.

1 стандартна доза = 10 стандартних напоїв

330 мл пива міцністю 3,5 - 5%	1 бокал 100 мл столового вина міцністю 11,5 - 13%	1 чарка 30 мл спиртних напоїв міцністю 40%
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